

The Modern Hospital

OCTOBER 1953

News and Pictures of A.H.A. Convention • Report of Staff-Administration Dispute at St. Vincent's Hospital, Indianapolis • A. D. A. Convention Report • Prototype of the 100 Bed Hospital • Doctor-Nurse Relations • Essentials of the Nurses' Residence

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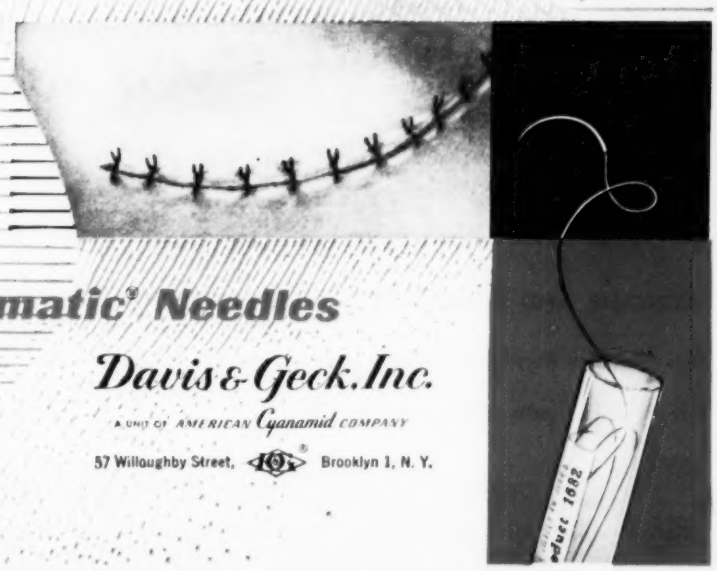
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* *Annals of Internal Medicine*, 37:465, 1952.

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AMONG THE AUTHORS


Arthur J. Snider

Arthur J. Snider, who went to Indianapolis to report the hospital-doctor dispute at St. Vincent's Hospital there (*p.* 51) has been science editor of the *Chicago Daily News* for the last seven years. A graduate of the University of Iowa, Mr. Snider was a reporter for the *Cedar Rapids Gazette*, then worked for International News Service and the United Press before going into the army. After the war, he took a master's degree in journalism at Northwestern University, where he was the first graduate student to prepare specifically for a career as a science writer. As science editor of the *Chicago Daily News* he has covered medical and hospital meetings and stories all over the country. He is president of the National Association of Science Writers and has contributed previously to The Modern Hospital, *Medical Economics* and other journals, in addition to covering science news for his paper.

Daniel S. Schechter, who made the survey of nurse-doctor opinion recorded on page 61 of this issue, is a free lance writer in New York City, where he has worked for the *New York Herald Tribune*, the Associated Press and other papers. While he was a student at Brown University, Mr. Schechter worked for three years on the staff of the university's news bureau. From November 1951 to June 1952, while attending Columbia University's school of journalism, he was a part-time correspondent for the *New York Herald Tribune*. He was also assistant managing editor of *Human Interest*, a social welfare journal.

Dr. Richard N. Kohl is assistant professor of psychiatry at Cornell Medical College in New York City. As a member of the staff of the Payne Whitney Clinic at the New York Hospital, his duties include treatment of patients, teaching, research and administration. His particular interest has been the application of psychiatric principles to the treatment of patients in general hospitals. This was the subject of a paper published in the *American Journal of Psychiatry* in 1951, and the paper on "Therapeutic Administration" on page 92 of this issue of The Modern Hospital.


Thomas Calero

Thomas Calero is a research assistant at the Industrial Relations Center of the University of Chicago, where he has worked on the development of the "employe inventory" described in his article on page 83 of this issue. Mr. Calero has been active in conducting and reporting employe opinion surveys with numerous business and industrial concerns. In addition, he has spent two years as an instructor in a Chicago technical college. He has received a master's degree in human development from the University of Chicago.


Richard Renck

Richard Renck, who worked with **Thomas Calero** in developmental research on the employe inventory and whose article on the inventory will appear in The Modern Hospital next month, is a research associate at the Industrial Relations Center of the University of Chicago. Formerly a field interviewer for a firm of management consultants in Chicago, Mr. Renck has a master's degree from the university in sociology and industrial relations. With Mr. Calero he is author of studies of the status characteristics of jobs in industry and reviews of industrial morale and attitude.

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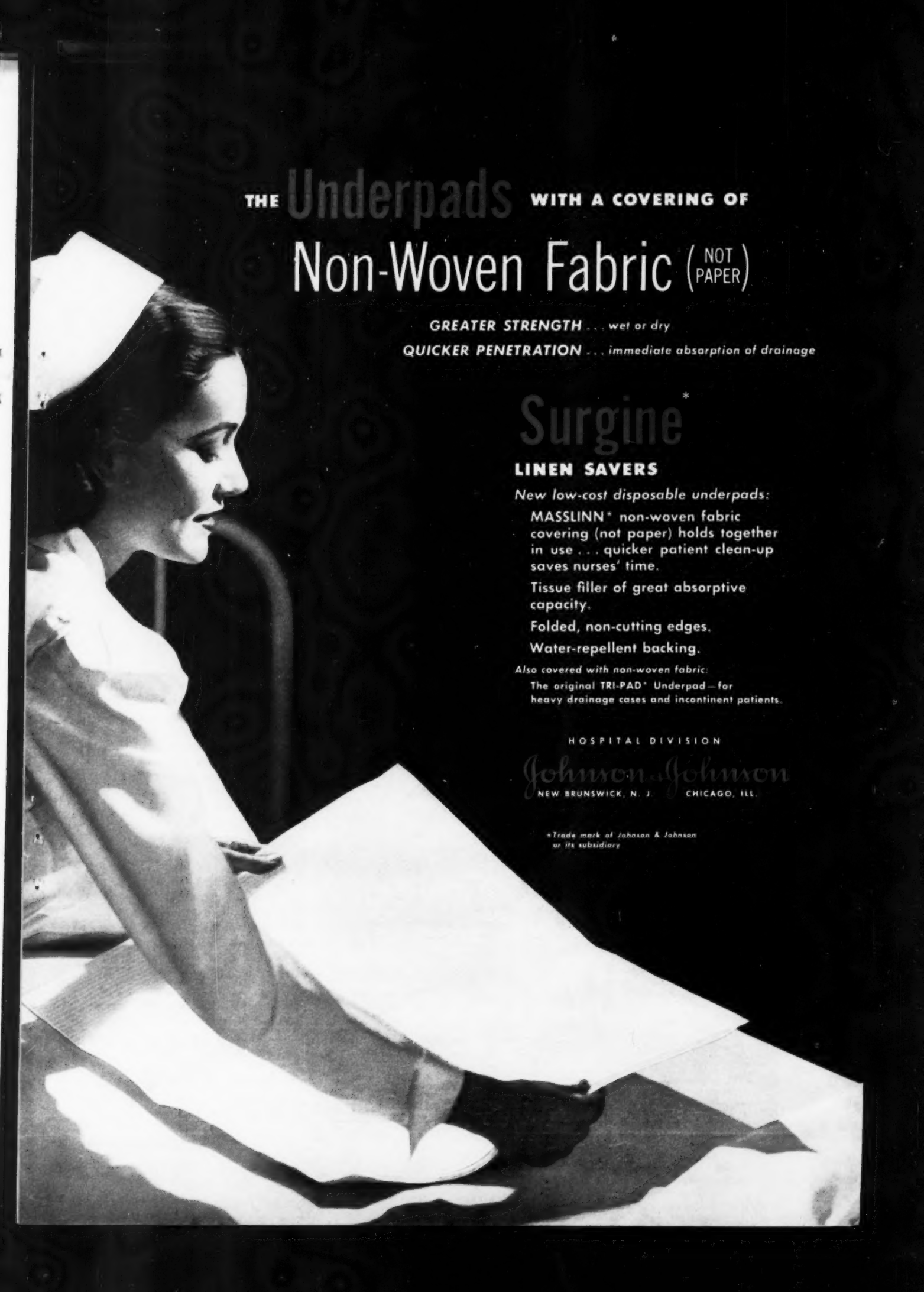
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Reader Opinion

Time and Motion

We have been very much interested in the series "Time and Motion Studies in Operating Suites" by Markus and Nocka which have been appearing in your magazine.

The application of these studies to the Lynn surgical suite in Lynn, Mass., (The MODERN HOSPITAL, May 1953) is most ingenious. It certainly revolutionizes conventional planning and should result in considerable saving in capital investment.

We do have several questions, however, to which we should like to have the answer:

1. Scrub-up facilities: There seem to be only two scrub sinks for two operating rooms. Most surgeons and supervisors we have dealt with insisted on three and wanted four. We realize the new germicidal detergents have cut scrubbing time to approximately three minutes; also that scheduling of operations so that two are not simultaneous reduces congestion.

2. Lightproof facilities: Some surgeons want completely controlled artificial light in a darkroom for certain procedures. With such an open plan this would be very difficult to achieve.

3. Septic cases: Can adequate segregation for the septic case, and particularly the postoperative clean-up procedures, be handled in such an open plan?

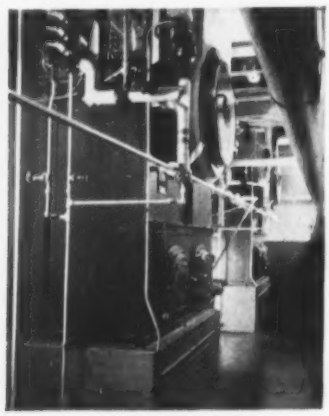
4. Acoustic treatment: Even though acoustic ceilings are provided throughout, we wonder if there is adequate sound control between areas where a delicate operation is going on and near by the clean-up gang is getting a room ready and telling a ribald story. Theoretically, there isn't time for horseplay but it does happen.

5. Mechanical equipment: The whole area is air conditioned but how can temperature and humidity be controlled in individual rooms to meet special surgical requirements and surgeons' idiosyncrasies?

6. Instrument clean-up: Hand washing of instruments sounds rather antiquated with the washer-sterilizers on the market. Markus and Nocka have worked closely with Dr. Carl Walter who has always been such a strong advocate of the washer-sterilizer at the operating room for minimum transportation of soiled and septic instruments. Is that theory out the window now? We are puzzled at the sink indication in this clean-up area (November 1952 also) with the three circles. Is this something special or a stock item?

7. Circulating nurse station: Is there any provision in one of the cabinets for warming solutions or must they be picked up at the central solution station? Obviously, flasked autoclaved solutions and distilled water will be supplied from a central sterile supply area elsewhere. We assume that the sterilizers indicated adjacent to scrub sinks are high speed 16 by 24 inch autoclaves.

8. Folding partitions between induction and operating areas: We have never found any such partition which we felt met the rigid cleanliness of an



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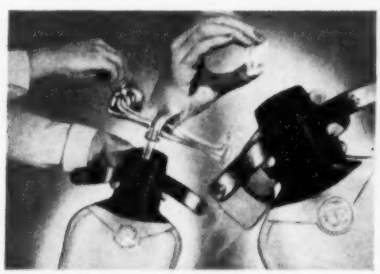
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operating room. Have we missed something new in the market?

We are not asking Markus and Nocka to reveal any professional secrets but they have been so generous in making their studies available that perhaps they will comment on our queries. Their research is very stimulating and should result in better hospitals.

Mary T. Worthen

York and Sawyer
Architects, New York City

(Miss Worthen's request for information was passed on to Mr. Markus, whose answers are given herewith.—Ed.)

Sirs:

Miss Worthen's letter raises some very interesting questions, and I shall herein attempt to present our thinking relative to them.

1. Scrub-up facilities: All the operating room suites we studied had their scrub-up facilities installed before the shorter scrub-up periods were in use. Nearly all supervisors could recall periods of congestion but we were never able to spot one. We have rechecked with these supervisors and with the shorter scrub-up periods they find no more congestion. In these hospitals, sinks or scrub stations averaged just about one per operating room. On this basis, there would appear to be no good reason for installing more than one scrub station per operating room. One of the supervisors also called our attention to the fact that surgeons do not all scrub by standing continually at the sink. While scrubbing, they may stroll to the window to view what is going on in the operating room, lean against the wall, or just walk around. In reality, therefore, more personnel can scrub at one time than there are scrub stations.

2. Lightproof facilities: The three minor operating rooms we have at Lynn Hospital will occasionally require semidarkness for certain eye, ear and nose work. For this we have filled curtains which can be drawn. While we have one extra opening here, we prefer this so that a single nurse may serve and circulate freely between the three rooms. Curtains also separate the induction areas from the operating rooms. For the fracture room, we have lightproof curtains on all openings to give a complete blackout for fluoroscopy.

It might be added that while the outside walls indicate continuous windows, all except those in locker rooms are black glass backed with insulation and plaster.

3. Septic cases: Remembering Carl Walter's often repeated statement, "Bacteria can't fly — they ride," the openings should make no difference, assuming, of course, reasonably dust-free air. In two hospitals where operating room doors are never closed no one appears alarmed about septic cases and the air is not even mechanically filtered whereas at Lynn it will be electronically filtered.

4. Acoustic treatment: In our observations, we have found the noise level in operating suites to be surprisingly low despite the fact that not much thought was given to this problem in the original design. The exception to this, and it is a big one, are the tonsillectomies. The child is brave and resolute until the very last moment when the ether can is poised, and then lets out a howl that could raise the dead. You'll note that at Lynn the minor operating rooms in which this work is done are cut off by soundproof doors. Other than that, we have found the noisiest spot to be the drainboards of the clean-up sink.



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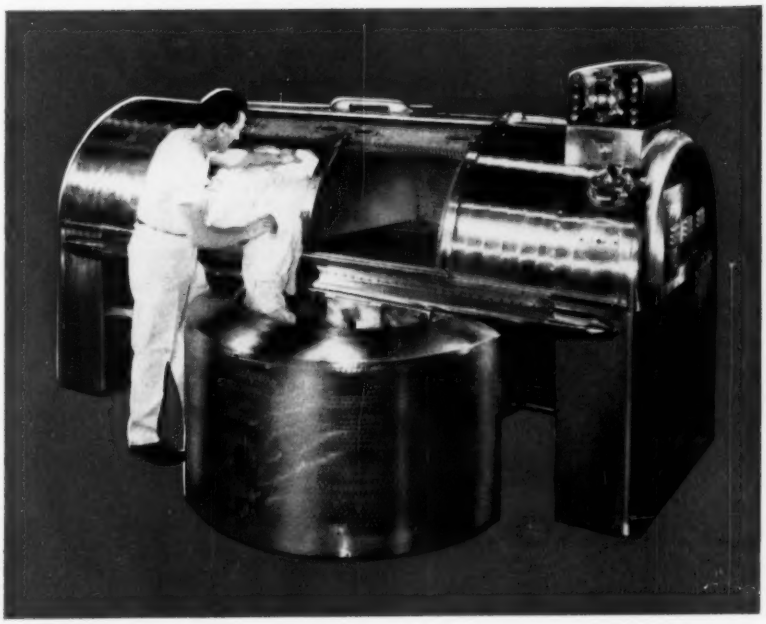
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6. Instrument clean-up: We feel that the washer sterilizer is ideal for instrument clean-up and provide one or more of these units in the clean-up area (near sink at Lynn). The three compartment sink is for incidental equipment. It was developed by us originally for hand washing of instruments. Its value becomes less when a washer-sterilizer is provided though it is still useful for rubber goods. The three circular compartments are served by one swinging spout. This gives one compartment for soaking, one for washing, and one for rinsing. A tube rinser is also provided. At the center point of the three sinks is a cup sink 6 inches in diameter. This is used for disposing of blood, pus or other liquids. By an indentation, the three large sinks overflow into the smaller center sink. A projecting ledge over the center gives the swivel spout its correct position and provides a convenient place for soap powder, used blade container, and so on. The sink is not yet standard equipment and must be made to order.

7. Circulating nurse station: The use of warmed solutions would appear to be getting less. We still generally provide an undercounter cabinet with fast closing refrigerator style hardware between each two operating rooms. At Lynn Hospital, the supervisor felt that one such cabinet centrally located was adequate. The sterilizer indicated between operating rooms will be a washer-sterilizer type with high-speed provisions.

8. Folding partition between induction and operating areas: Our terminology was at fault. The curtain previously mentioned is being used.

Frederick E. Markus
Markus & Nocka
Boston

Roving Reporter

How to Have an Accident

Twelve accident hazards were uncovered at St. Francis Memorial Hospital, San Francisco, at a safety meeting recently held for employes. A safety engineer for an industrial company spoke at the meeting, which was held in two sections so that all employes could attend.

Those attending the meetings compiled the following list of contributing factors to hospital accidents and injuries:

1. Spilled liquids.
2. Suddenly opened doors.
3. Objects on floors or stairs.
4. Bed rail adjustments.
5. Contact with hot objects.
6. Injuries from sharp objects.
7. Failure to follow instructions.
8. Disposal of refuse in linen chute.
9. Haste.
10. Improper arrangement of furniture and equipment.
11. Carelessness in smoking.
12. Improper posture when lifting patients.

To help employes avoid these pitfalls, the hospital has a safety committee, headed by the purchasing agent, whose duty it is to make rounds and take note of situations detrimental to safety.

To Keep Patients Happy

A goal of 10 volunteer receptionists in the outpatient department of Massachusetts General Hospital, Boston, has been set. This follows a pilot plan inaugurated recently under which a volunteer, Mrs. Herbert Barry, Jr., has been giving two mornings a week to all the clinics on the second floor of the department.

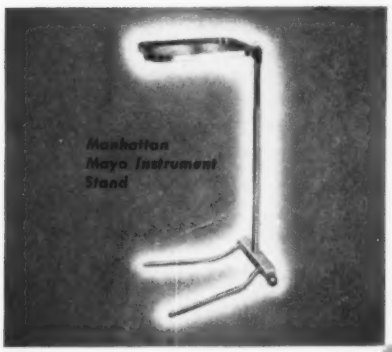
Mrs. Barry's job is to keep patients happy. It is her task to explain to patients the unavoidable wait that follows a delayed record or a doctor's

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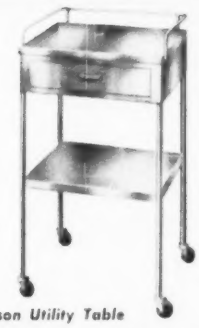
• Many prominent institutions have standardized on these Blickman-Built operating room units. Their highly-polished stainless steel surfaces ground static charges effectively through electrically-conductive casters and floor tips. Sturdy, seamlessly welded construction assures long service life. Elimination of dirt-collecting joints and crevices facilitates cleaning. Before buying operating room equipment, see and compare the advantages of "Blickman-Built."

SEND FOR BULLETIN 9 ORC . . . . illustrates and describes more than 50 different Blickman-Built stainless steel units of operating room equipment.

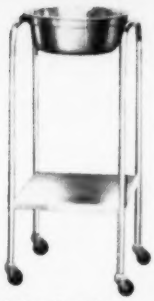

Manhattan Maya Instrument Stand

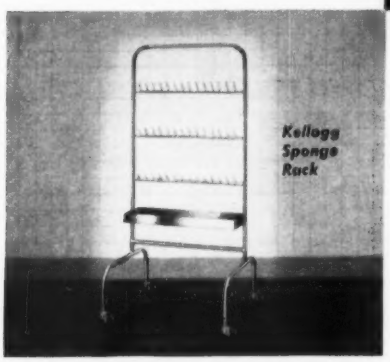

Howard Instrument Table

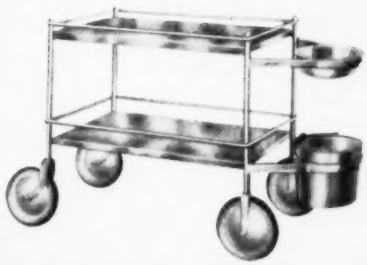

Clifton Revolving Stool

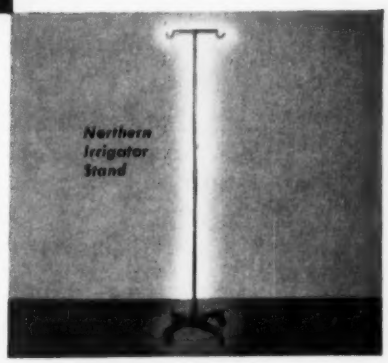

Ferguson Utility Table


Graystone Curved Instrument Table

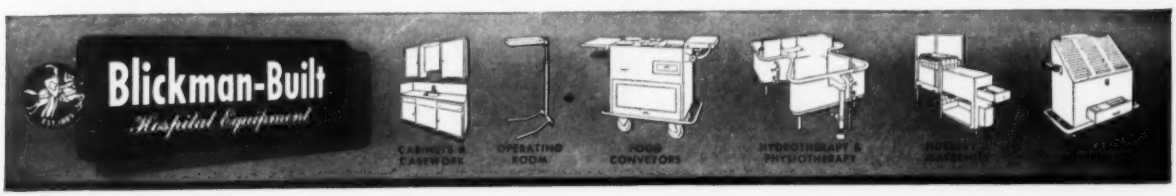

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being detained by an emergency. She brings coffee from the OPD lunch counter to patients who are unable to get it for themselves. She explains the doctor's instructions to them in simple terms; she offers magazines to those who must wait a considerable time. Most important of all, she listens sympathetically to harassed patients' unburdening themselves.

That the pilot plan is a success is attested by nurses, secretaries and other OPD personnel who find the atmosphere much happier on the days Mrs. Barry is around. MGH is now seeking volunteers who will give one or more mornings each week to this task.

The Goal Is Cleanliness

With its goal of "Cleanest Hospital in the Land," housekeeping employes at Southern Baptist Hospital, New Orleans, are well advanced on their "Better Housekeeping in 1953" program.

Each month the best groomed maid and porter get a prize and their pictures appear in the employes' publication, the *Triangle*. (In case you wonder what the triangle signifies, it's Science, Skill and Service.)

Mrs. John Maggiore, the executive housekeeper, is quick to consider suggestions for improvements from the suggestion box that has been set up especially for maids and porters. A weekly prize is being given for the best suggestion.

The first step in the better housekeeping campaign was the accelerated training program set up for supervisors and workers. Weekly class sessions are being held for each group under the direction of Mrs. H. G. Tew, the administrative assistant.

The housekeeping office and storeroom have been renovated, with new supply lockers placed on each floor. This system has made the goal of "cleanest hospital" more nearly attainable.

Glamour in the Locker Room

For glamour no country club in the nation can top the locker room facilities that have been opened in the subbasement of the nurses' residence of New York Hospital, New York City. A lounge adjoins the locker room. Attractive lounges are the expected thing, but it's the locker room that the 500 nurses on the hospital staff boast about to their friends.

Among the features to be found in the new locker room, built on the site of the former gymnasium, are thermostatically controlled air conditioning, indirect lighting, make-up mirrors at the end of each group of lockers, and a large full length mirror paneling one wall.

The color scheme is particularly delightful, the nurses find. Coral walls contrast softly with turquoise lockers and ivory plastic covered dressing benches. In addition to the dressing facilities, equipment for pressing uniforms and cleaning shoes has been provided in a utility room.

Across the hall from the new locker room, a lounge decorated in light green and gray offers the nurses a pleasant air-conditioned spot for off-duty relaxing. The modern furniture will be made of wrought iron and upholstered in light green plastic.

Three hundred and ninety lockers are available in the new locker room, and 206 more will be installed in the existing basement level locker rooms currently being reconstructed. Eventually a total of 596 lockers will be provided for the use of the nurses.

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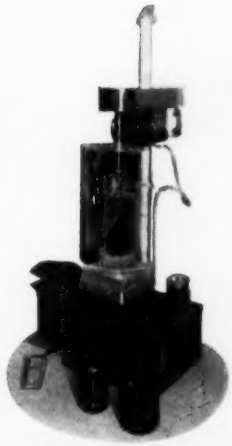
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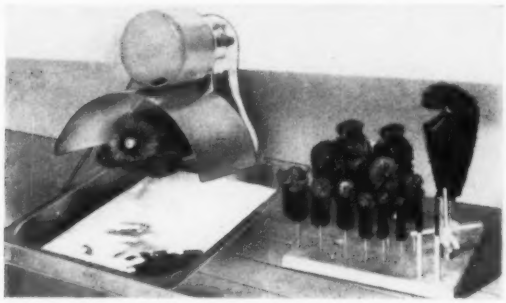


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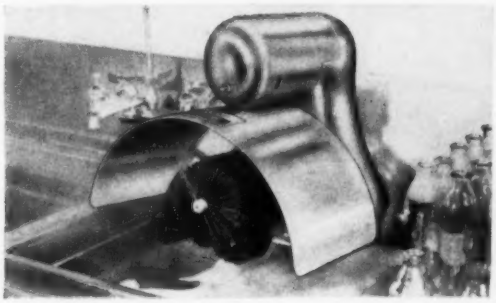
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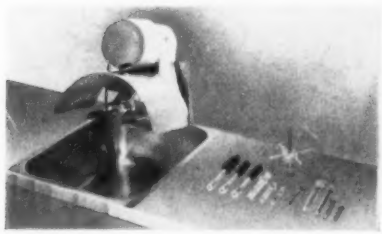
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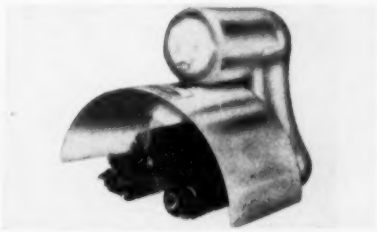
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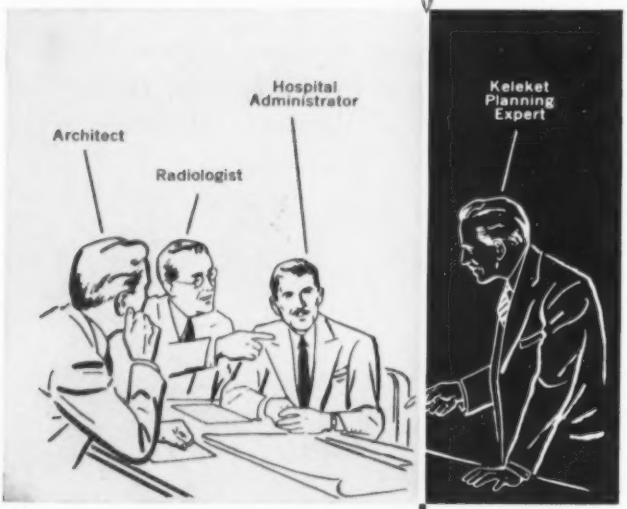
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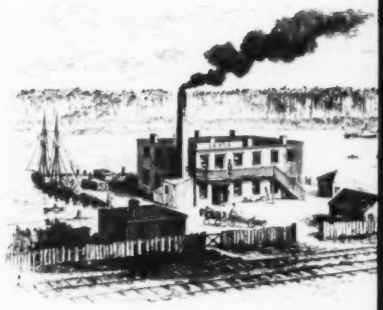
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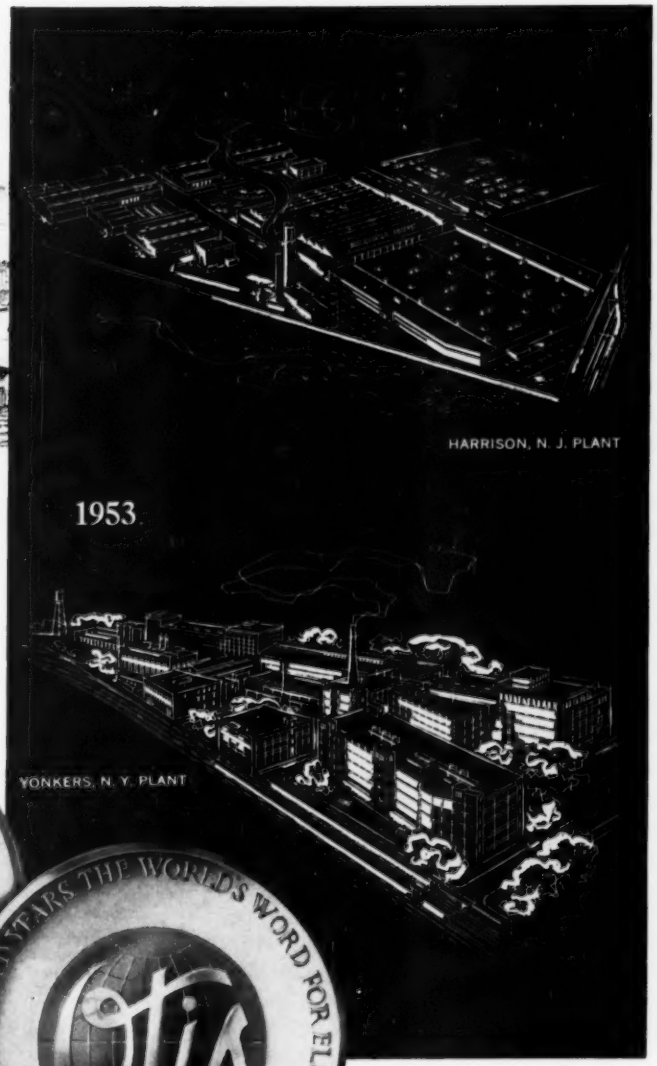
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The year 1953 is for Otis both an end and a beginning. It is the end of a century during which the name, Otis, became synonymous with the word, elevator; it is the beginning of a second century of continued Otis leadership and development in the field of vertical transportation.

During the past hundred years, the men and women of Otis have, by hard work, trial and error, and occasional flashes of genius, built a company and a product of which we today have just reason to be proud and, in the doing, they have contributed greatly to the building of their country.

(continued on next page)

the Otis heritage

During this first century, there evolved an Otis organization whose character reflects the composite character, judgment and ideals of those leaders of the past who, generation after generation, selected and trained and inspired this organization. It is an organization whose roots go deep into the past, and which has a tradition of loyalty to the Company not easily understood by those who are not a part of it.

Similarly, the organization of the future will, to a considerable degree, reflect the judgment, character and ideals of those who now have a voice in the selection and training of those who will follow us. Clearly, it is our obligation to pass on to our successors an organization no less qualified for their task than the organization which we inherited and with which we have had the privilege of working.

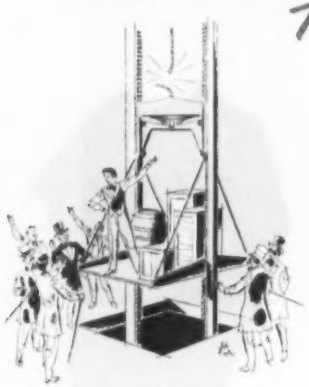
During the past century, Otis established and maintained a reputation for designing, manufacturing and installing the best elevators available. At the same time, we built a reputation for trustworthy performance and fair dealing, which resulted in our becoming not only the world's largest producer of elevators but also a producer whose product commands a premium price.

That this position is not the result of chance, but rather is the result of a deliberate policy and of a conscious goal, is evident from the objectives outlined by Charles Otis in 1877:

"It should be our aim", he said, "to make our work satisfactory to our customers, not alone until we get our pay for each particular job, but until we get paid for every job we ever intend or expect to do for anyone, to the end of time; to get every customer we can and to keep every one we get – both for his work and for his influence.

"We must keep in mind", he said, "that the great objects of doing business are (1) to give occupation, (2) to achieve success, and (3) to make money, and that we shall not accomplish very much of the first two of these objects if we fail in the last."

SOME OTIS "*Firsts*" OF THE FIRST HUNDRED YEARS



1853—Elisha Graves Otis invented the first safe elevator. It was equipped with a safety device to prevent the elevator from falling if the ropes should break, which was a frequent occurrence in those days. Until a safe elevator became available, buildings and cities had grown vertically only as high as people were willing to climb stairs.

1878—The first high speed hydraulic elevator, introduced by Otis Brothers and Company made the first "skyscrapers" economically possible. These elevators were capable of higher speeds than the then existing methods of control made it practicable to use, and car speed was, therefore, limited to 700 feet per minute.

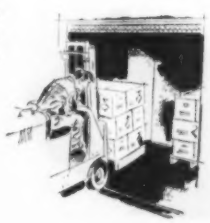
1889—The first Otis electric drum elevator was installed in New York City. The application of electricity to elevators made possible many new types of control, and the use of electric door interlocks added greatly to elevator safety.

1892—The first elevator to be controlled by variable voltage supplied by a separate motor generator was installed by Otis Brothers and Company in New York City under license from Ward Leonard. This type of control, which is now used on all high speed Otis elevators, provides smooth and rapid acceleration and retardation and contributes immeasurably to the quality of operation.

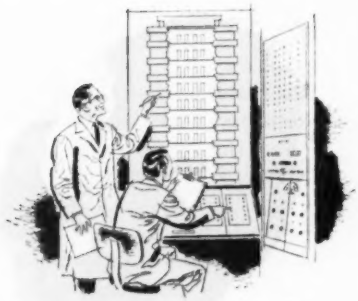
1900—The first Escalator was exhibited by Otis Elevator Company at the Paris Exposition and was awarded a grand prize. Until 1950 the word "Escalator" remained an Otis trademarked name, but is now in common use as a part of the English language.



1903—The first electric gearless traction machine was developed and installed by Otis. Gearless traction machines can be used for any desirable speed and rise and are extremely durable. To our knowledge, no Otis gearless machine has ever worn out.



1915—The first self leveling, or Micro-Drive, elevators were developed by Otis engineers and enable passenger and freight elevators to be brought to an accurate stop at floor landings and to maintain this level automatically. This development saves time, eliminates the stumbling hazard and permits trucks to run smoothly on and off an elevator platform.



1953—The first traffic duplicating equipment was designed by Otis engineers to facilitate research and to demonstrate elevator performance. This electronic device is used to impose upon a group of model elevators in any desirable order all of the traffic conditions that, under any circumstances, could be created by the passengers in an intensive service office building. It then demonstrates by actual performance how such traffic is handled by Otis Autotronic — Without Attendant — Elevators with a fully automatic electronic group supervisory system.

This ingenious electronic device is effective, not only in demonstrating the performance of existing equipment, but, by providing Otis engineers with a laboratory which furnishes a prompt and accurate reading on the utility of new developments under actual operating conditions, it gives added assurance that the Otis leadership which has been so outstanding in the past will be continued in the years to come.



1950—The first group supervised intensive service elevators, designed to operate without attendants in the cars and equipped with electronically protected car and hatchway doors, were installed by Otis Elevator Company in the Atlantic Refining Company Building in Dallas, Texas. Such Autotronic–Without Attendant—Elevators have demonstrated their ability to render excellent service and to save up to $7,000 in operating costs per elevator per year.

1948—The first automatic and electronic supervisory system (Autotronic®) was developed by Otis to secure maximum quantity and quality of performance from a group of intensive service elevators and to vary the plan of operation to suit the changing requirements of the traffic.





At this time, also, the Otis Electronic Touch Button was made available which, at the lightest touch of a fingertip, is brightly illuminated and simply and dependably stops the elevator automatically at the desired floor.

1925—The first full Collective Control elevators were developed by Otis, primarily for use in apartment houses and hospitals. These elevators are passenger operated but furnish service substantially equivalent to that secured with an attendant operated elevator.

1924—The first Signal Control elevators, developed and installed by Otis, enable elevators to operate with speeds in excess of 700 feet per minute and to stop accurately and automatically in response to the pressure of hall or car buttons.

our goal for the future

At the beginning of our second century of operation under the name of Otis, it is appropriate to consider what we *now* regard as our purpose and objective and what we *now* believe to be the justification for our continued existence.

Without attempting to be epigrammatical, it seems to me that our objective should be:

To build the best products in our field; to continually improve these products in design and in method of production and installation so that they can continue to be sold at a profit sufficient to

(a) permit payment to investors of a return on their investment which will furnish an adequate incentive to save and invest in this or other useful competitive enterprises,

(b) permit stable employment of a carefully selected and trained organization,

(c) make possible such wages, salaries and working conditions as will result in the maximum incentive and capacity for production for the ultimate good of the greatest number.

This objective is based on the belief that the greatest good for the greatest number can result only from maximum production of useful goods equitably distributed. It is also based on the belief that maximum production is obtainable only through competitive enterprise, with such incentives as are necessary to prompt capital to provide the required tools and to stimulate all types of labor to the greatest possible productive effort consistent with their spiritual and physical well being.

It will be noted that, in common with Mr. Charles Otis, it is recognized that, first and foremost, the purpose of a business must be to satisfy its customers to the end that they will continue to buy the product at a profitable price. Failing in this, all other objectives must be abandoned—including the fundamental objective of continued operation.

Obviously—a successful business must provide for its own future existence, if it is to accomplish anything else. However, mere existence is the *minimum* requirement. The real justification for a company's survival must be measured by the contribution which it makes to the general welfare.

In common also with Mr. Otis, we recognize the importance of providing employment—but only when employment results in, or contributes to, useful production or gratification of human needs. Employment which merely wastes time is a criminal waste of human lives and human energy and is grossly inconsistent with the objectives of a legitimate business.

our personal obligation

The ideal for which we should strive is a company which provides every person in its organization with frequent opportunity to test his maximum capacity and which provides a constant incentive to increase that capacity and to devote it to useful ends.

(continued on next page)

There is so much in this world that requires doing and the doing of it requires so much human energy and intelligence that we cannot tolerate that which wastes this energy and intelligence and which stultifies the ambition which is necessary to make it do useful work. We must measure our own individual success not primarily by the position we attain but by the extent to which we are utilizing to the utmost the talents and capacity with which we are individually endowed and also by the extent to which we make it possible for others to do the same thing.

the role of competitive enterprise

The United States has reached a position of world leadership primarily, I believe, because, throughout the greater part of its history, emphasis has been laid upon the importance of the individual and upon the importance of maintaining individual opportunity and powerful incentives for individual effort and accomplishment. The resulting competitive enterprise has produced a standard of living and a capacity for production the like of which the world has never seen.

Nevertheless, there has arisen a contrary philosophy, backed by the ruthless power of a foreign dictator state, and the American system of living and producing is on trial before the world.

the challenge to American business

Now, at long last, the American people have once more called upon American business men to restore the faith of the country in the basic principles upon which our nation was established and to stage such a demonstration of the advantages of democratic competitive enterprise that the fallacy and folly of socialism and communism will be self evident to all the people of the world who are free to learn—and, ultimately, even to those behind the iron curtain.

It is a crisis greater than any previously faced by the American people and a challenge to the business men of the country which they must accept or fail miserably in the defense of the principles in which they have professed a profound belief.

our share of the job

As a part of the business world, we share in the obligation to demonstrate the superiority of our system of democratic competitive enterprise in providing for the general welfare.

Our share in this demonstration is to so work and so manage the affairs of our Company as to help raise the level of accomplishment of the business community. Then confidently, aggressively, persistently and intelligently we must acquaint, first of all the people of our own country and then the other people of the world, with what business is, has done and can do and the vital part which business has played and must continue to play in building up and maintaining the standard of living, way of life and defense of our country.

The Otis Elevator Company is to thousands of employees, stockholders and customers a representative of business and an example of the operation of the competitive enterprise system. It should be our purpose to make that example a good one.

R. A. Peterson

President

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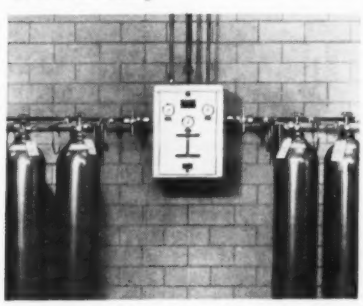
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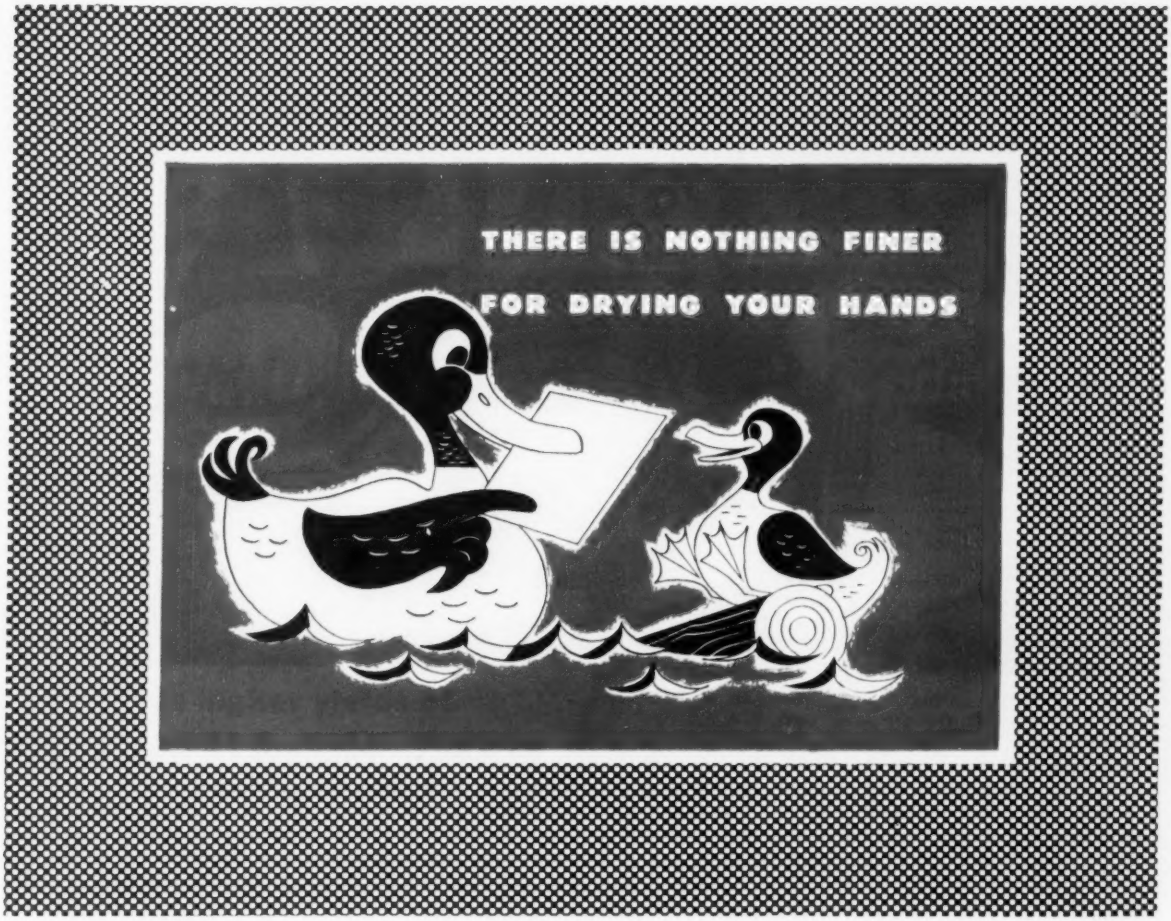
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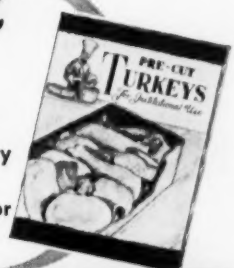
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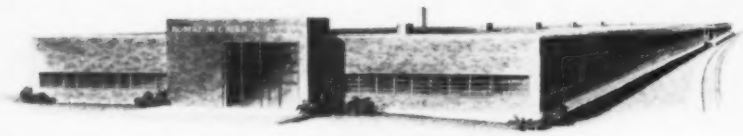
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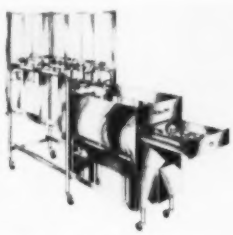
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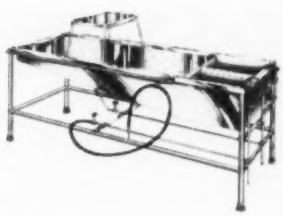




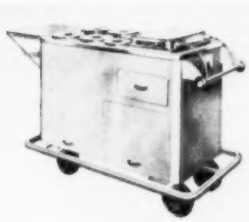
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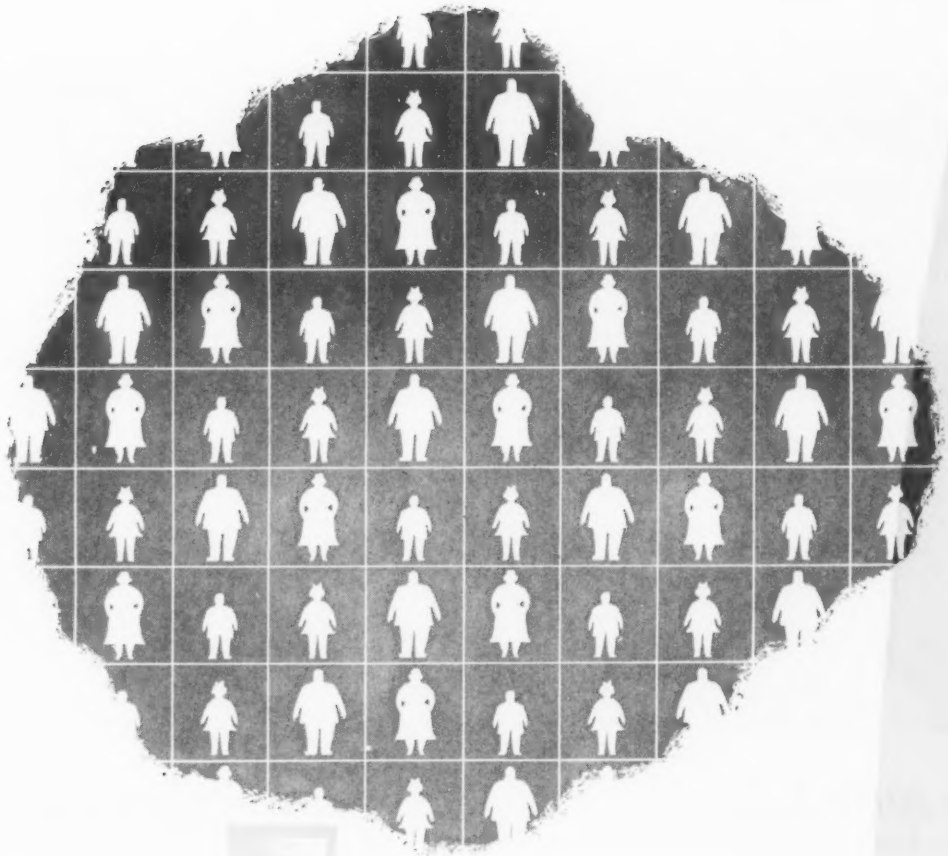
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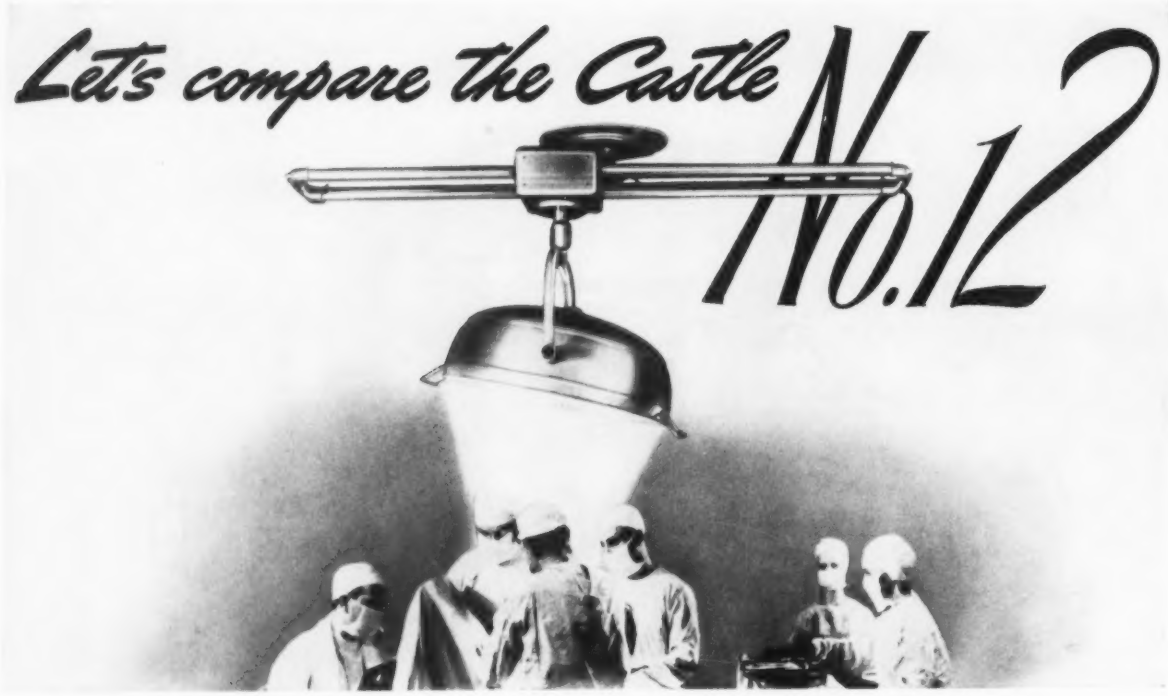
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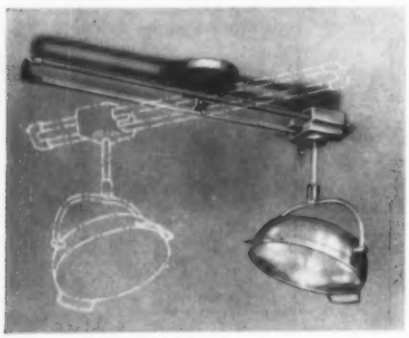
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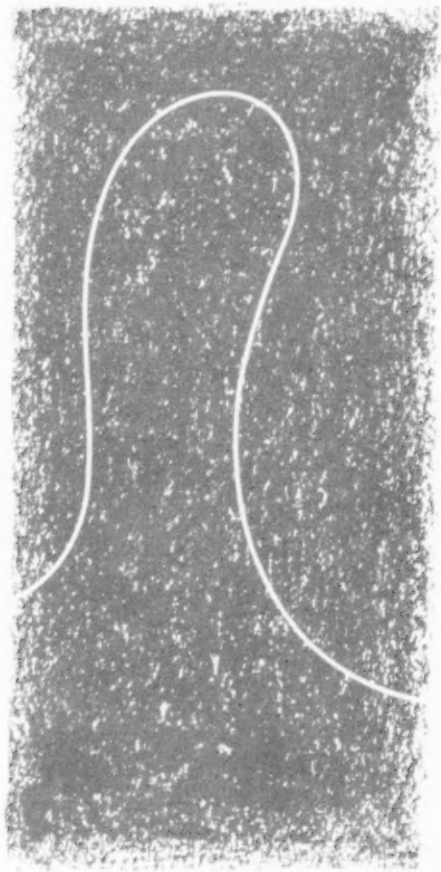
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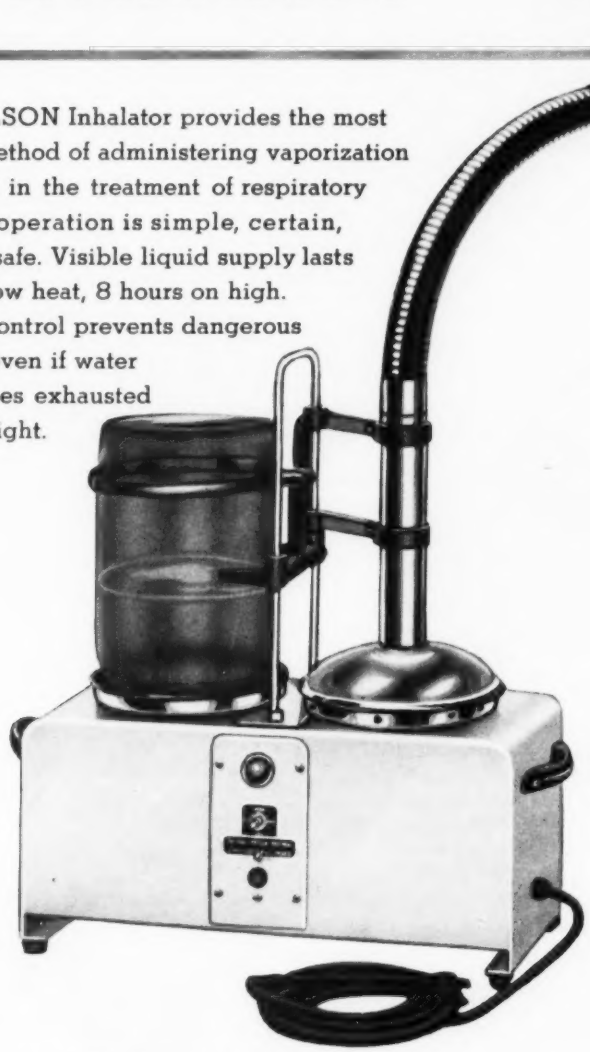
laboratory sterilized in sealed tubes

*T.M.

The New Colson® Inhalator

provides safe, convenient and *effective* treatment of respiratory diseases

The new COLSON Inhalator provides the most satisfactory method of administering vaporization or inhalations in the treatment of respiratory ailments. Its operation is simple, certain, effective and safe. Visible liquid supply lasts 16 hours on low heat, 8 hours on high. Trouble-free control prevents dangerous over-heating even if water supply becomes exhausted through oversight.



Features of New COLSON Model 4953 Inhalator

- Stainless steel boiler, reservoir, medicine cup and flexible tube.
- Visible water supply.
- Uninterrupted operation while replenishing water supply.
- Easy access to medicine container.
- Trouble-proof thermal switch to prevent damage if water supply is exhausted.
- High and low heat.
- No fuses or thermostats.
- Approved by Underwriters' Laboratories and Canadian Standards Association.



Model 4970 COLSON Inhalator Dolly provides complete portability—can be used either with new or previous model

THE COLSON CORPORATION

ELYRIA, OHIO

WHEEL CHAIRS • • WHEEL STRETCHERS • • INHALATORS • • INSTRUMENT TABLES

if you kept a car in the lobby... it still couldn't hurt this great new resilient tile...



CONGOLEUM-NAIRN INC

Kearny, New Jersey © 1953

GOLD SEAL Vinylbest



Sounds Impossible? But new Gold Seal Vinylbest Tile takes practically any kind of abuse in its stride. In this remarkable new quality tile you'll find—

All the grease and alkali resistance of vinyl.
All the true color characteristics of rubber tile.
All the easy maintenance features of inlaid linoleum.
Plus all the moisture resistance of asphalt tile.

When you want an all-purpose, flexible, durable, good-looking tile—specify Gold Seal Vinylbest. It's guaranteed* for installation on, above or below grade. It takes to concrete as readily as it takes to wood. And it positively will not support combustion.

This new wonderfloor is offered in thirteen $\frac{1}{8}$" patterns in a distinctive foam marble decoration. The famous Gold Seal system of Color-Correlation permits an unlimited variety of decorative effects. Yet Gold Seal Vinylbest Tile is installed quickly and inexpensively with asphalt tile adhesive.

**The famous Gold Seal guarantees satisfaction—or your money back.*

For free color folder, fill out the coupon.

Congoleum-Nairn Inc.
Architects' Service Department
Kearny, New Jersey
Please send me the free color folder on Gold Seal Vinylbest.

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City_____ **Zone**_____ **State**_____

Gold Seal Floors and Walls
®

Check the popularity

of these low-cost desserts





Easy to make! Easy to serve!

PRUNE BROWNIES

1½ cups shortening	1 Tbsp. baking powder
1½ pints sugar	1½ tsps. salt
6 eggs	1 qt. sifted flour
1 Tbsp. vanilla	1½ cups chopped walnuts
6 oz. unsweetened chocolate	1½ pints chopped, cooked California Prunes

Cream together shortening and sugar until light and fluffy. Add eggs one at a time, and beat well. Stir in vanilla. Melt chocolate and add to creamed mixture. Sift baking powder, salt, and sifted flour together; combine with nuts. Stir into creamed mixture. Combine with prunes. Spread into two greased 13" x 9" x 2" baking pans. Bake in moderate oven (350°) 35 to 40 minutes or until done. Cool slightly and cut into 2" brownies *(makes 48)* or 1½" x 2" brownies *(makes 64)*.

A favorite with *all* ages!

PRUNE CRUNCH

3 qts. pitted California Prunes (6 lbs.), cooked without sugar	½ lb. butter or margarine
5 cups juice from prunes	1 pint brown sugar, firmly packed
1½ cups sugar	1 pint sifted flour
1 pint chopped walnuts	2 tsps. baking powder
	1 pint rolled oats, uncooked

Arrange prunes in two 12" x 7" x 2" pans. Pour half of prune juice and sugar into each pan; sprinkle with nuts. Cream together butter or margarine and brown sugar until light and fluffy. Sift together flour and baking powder. Stir into creamed mixture. Add rolled oats. Spread over prunes. Bake in slow oven (325°) 50 to 60 minutes or until topping is done. Serve warm with custard sauce or thin cream. *Makes 48 servings.*





And a perfect "pick-me-up," too— just as they come from the package!

Here's the ideal mid-morning or afternoon snack, because everyone likes prunes' tangy-sweet flavor. And they're such a rich source of energy-providing fruit sugar—of protective vitamins and minerals, too. So for good eating *and* good health, include the California wonder fruit often.

Serve plenty of hearty

PRUNES

the California wonder fruit!

FREE! book of tested formulas!

Salads, whips, pies, cakes, other favorites made extra appealing with California Prunes. Send card for your copy. California Prune Marketing Program, 2 Pine Street, San Francisco, California.



only Bolta *gives you*

COLOR-and-PATTERN HARMONY

in LAMINATED TRAYS



Also Famous Boltalite Hard Rubber Trays
in Sizes 12 x 16 and 14 x 18
Also Boltabilt Trays in Round, Oblong and
Oval Shapes in 15 Different Sizes

For extra sparkle and beauty in meals served to patients, use BOLTA LAMINATED COLOR TRAYS with their richer, more elegant finish. Designed in 36 different color-and-pattern combinations, they match or contrast with any decor. BOLTA COLOR TRAYS offer extra economy, too, because they laminate seventeen — yes, seventeen — separate layers to give up-to-ten-times greater strength than ordinary trays. That means two-to-six-years longer wear . . . and longer wear means lower cost.

Only BOLTA gives you such outstanding durability in patterns and colors.

- Non-porous, satin-smooth surfaces
- Impervious to cigarette burns, food acids, alcohol, fruit juices
- Lightweight, noiseless, easy to handle
- Washable in mechanical dishwashers
- Will not warp, split or stain
- 8 x 10, 10 x 14, 12 x 16, 14 x 18, 15 x 20

The BOLTA *Company*
LAWRENCE
MASSACHUSETTS

Planning to Re-decorate? Specify BOLTAFLEX *for booths and furniture,* BOLTA-WALL *for interiors*

Used in the Most Prominent Buildings



POWERS

WATER TEMPERATURE CONTROL

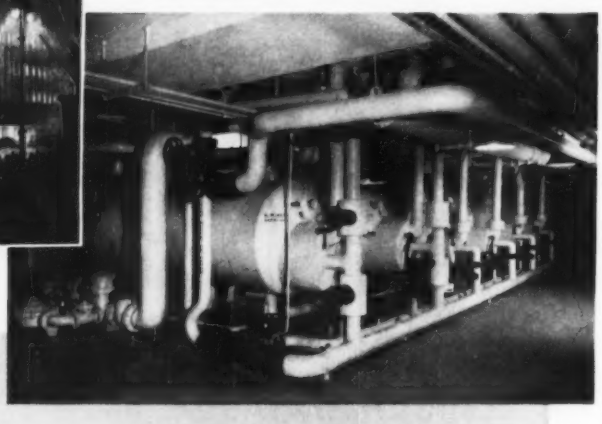
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John Hancock

MUTUAL LIFE INSURANCE COMPANY BUILDING

Water Heaters, six of which are shown below; 21 Shower Baths; 7 Dishwashers in the company cafeterias; Photostat Developing Baths for two large photostat machines . . . all are regulated by various types of POWERS Thermostatic devices especially suited for their particular use.

When problems of temperature control arise phone or write POWERS nearest office. With over 60 years' experience and a complete line of controls, some of which are shown below, we can help you find the right solution for your requirements.



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McCarron & Sullivan Co., Plbg. Engineers; M. Ahern & Co., Contractor
Buerkel & Co., Heating Engineers & Contractors

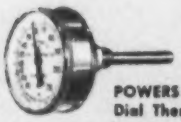
Powers ACCRITEM Regulator



Compressed air or water operated for controlling all types of water heaters, and diesel engines.



Powers FLOWRITE Valve

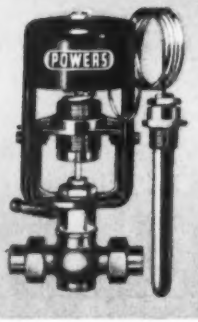


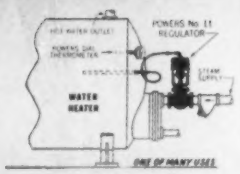
POWERS Easy to Read Dial Thermometer



POWERS Thermostatic Water Mixer. Insures utmost comfort and safety in showers. Many other uses.







POWERS No. 11 Self-Operating Temperature Regulator for water storage heaters, hot water converters, dishwashers, fuel oil preheaters, jacket water cooling for air compressors, and diesel engines, etc.

(b29)

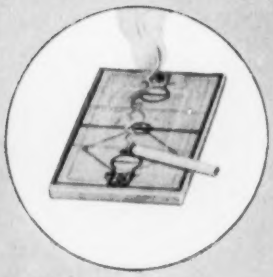
Established in 1891 • **THE POWERS REGULATOR COMPANY** • SKOKIE, ILL. • Offices in Over 50 Cities



LET'S START WITH THE CAUSES OF *COSTLY FLOOR CARE*

Floor maintenance costs can be cut. Without skimping on protection. The way we help you do it is simple. First we look for the trouble spots that we've found are typical causes of extra expense. We analyze the treatments each of your floors has been getting. Then we cross-check these methods with those that have proved most successful in our years of experience with floors of all types, ages, conditions, and traffic situations.

After this analysis, we help you to organize your floor care on the most efficient basis. To set up a timetable for systematic cleaning, sealing, maintaining, and inspecting. To choose the particular products in West's broad line that will best fit your needs. At the right are a few examples.



Let's see how WEST products cut floor costs

West's broad line of floor products includes every item needed to clean, seal and maintain any type of floor. Economically! Here are three outstanding items.

LASTINCOTE

seals floors extra tight against dirt, oils, greases, scuff marks, scratches. Even a lighted cigarette won't mar the finish, although the wood underneath may char. Lastincote goes further and lasts longer. Penetrates deep into pores of surface, creating a hard, antislip coat. Completely neutral. Impervious to strong alkalis, soaps.

LUSTRECLEAN

is a triple action cleaner. Cuts maintenance man hours by cleaning, deodorizing and lightly waxing in one operation. No rinsing! Excellent for wood, composition tile, asphalt tile, linoleum, cement, terrazzo, painted and varnished floor surfaces.

KWYKWAX

provides a hard, antislip coating. Dries to high gloss in 20 minutes. Resists wet rainy-day traffic. Lasts and lasts for extra savings.

WEST DISINFECTING Company

West's broad line of products includes not only floor maintenance materials but also washroom service . . . disinfectants . . . deodorants . . . insecticides . . . cleaners . . . soaps . . . protective creams. West is also the exclusive distributor of Kotex Sanitary Napkins sold through vending machines.

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WANT DETAILS?

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Dept. 12

I'm interested in:

☐ A FREE booklet packed with floor know-how and tips that can save hundreds of man hours a year.

☐ A talk with a West expert about my special floor problems. No sales pitch. No obligation. Just discussion and a demonstration if I want it.





Patients care for themselves sooner, when there's a lavatory in their room . . . and Crane's new Hygiene Lavatory is specially designed for patient's use.

New Crane Lavatory Saves Nurse Power

Most hospital administrators find the continuing shortage of nurses a major problem. That's why equipment that saves nurse's time and effort can pay for itself in short order.

That's why Crane's new Hygiene Room-Lavatory is a welcome aid to hospital efficiency and economy. Installed in a room or ward, it does these two important things:

1. **Saves countless steps by bringing water to the nurse—right where she needs it.**
2. **Saves further nurse-power by encouraging convalescent patients to help themselves.**

In fact, it is the only lavatory specifically designed for patient's use. It has a handy shelf (right or left side of the basin) for toilet articles, glasses and the like . . . high, gooseneck water spout with Spring-Flo aerator . . . and easy-operating, wrist action Dial-ese controls.

This is one of Crane's complete line of hospital fixtures—every one made especially for hospital use. Consult your Crane Hospital Service Catalog for details. If you don't have a copy of the catalog, ask your Crane Branch or Crane Wholesaler.



Cuts maintenance time and expense. This simple cartridge contains all the moving parts of Crane's Dial-ese faucet control. Fits all Crane Dial-ese faucets, can be slipped out and replaced in a matter of seconds.

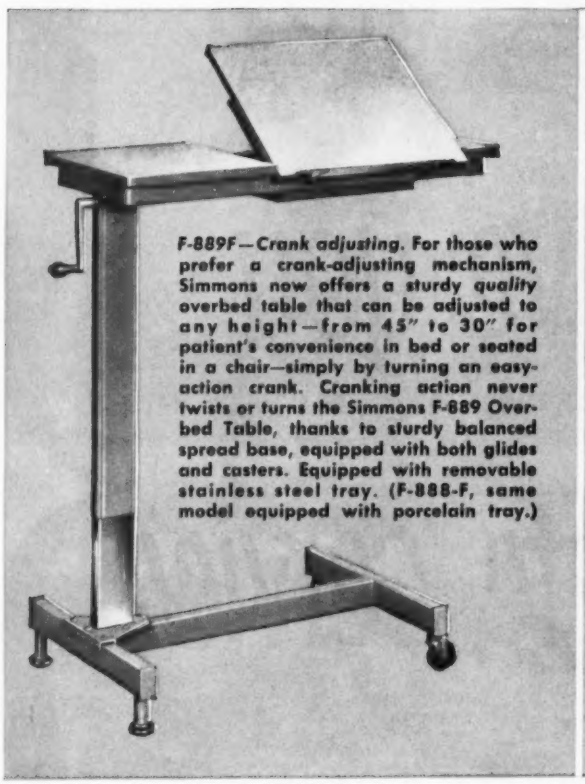
CRANE CO.

GENERAL OFFICES: 836 SOUTH MICHIGAN AVE., CHICAGO 5

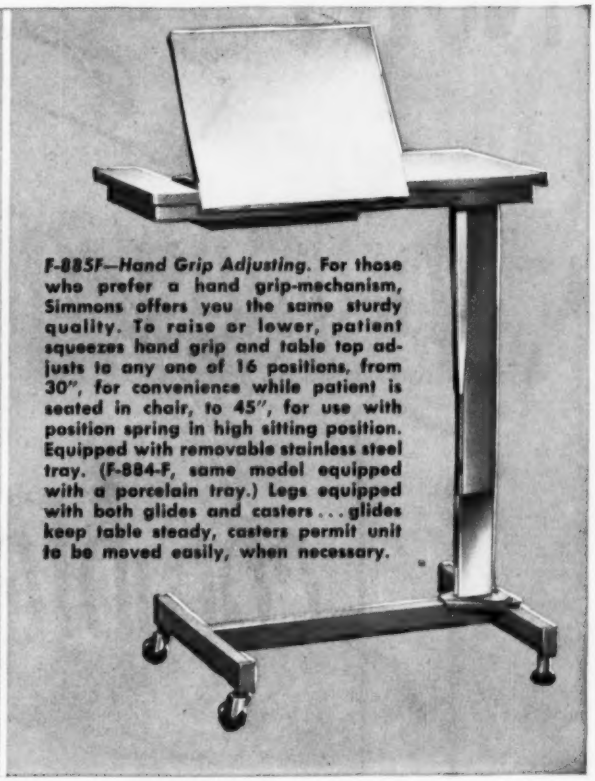
VALVES • FITTINGS • PIPE
PLUMBING AND HEATING

...now you can choose between 2 Overbed Tables

FROM SIMMONS COMPLETE LINE



F-889F—Crank adjusting. **For those who prefer a crank-adjusting mechanism, Simmons now offers a sturdy *quality* overbed table that can be adjusted to any height—from 45" to 30" for patient's convenience in bed or seated in a chair—simply by turning an easy-action crank. Cranking action never twists or turns the Simmons F-889 Overbed Table, thanks to sturdy balanced spread base, equipped with both glides and casters. Equipped with removable stainless steel tray. (F-888-F, same model equipped with porcelain tray.)**

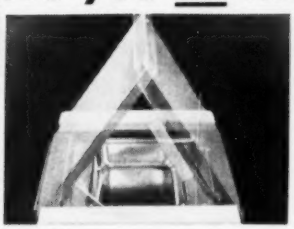


F-885F—Hand Grip Adjusting. **For those who prefer a hand grip-mechanism, Simmons offers you the same sturdy quality. To raise or lower, patient squeezes hand grip and table top adjusts to any one of 16 positions, from 30", for convenience while patient is seated in chair, to 45", for use with position spring in high sitting position. Equipped with removable stainless steel tray. (F-884-F, same model equipped with a porcelain tray.) Legs equipped with both glides and casters . . . glides keep table steady, casters permit unit to be moved easily, when necessary.**

both give you <u>all</u> these quality features



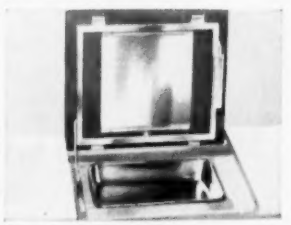
Ever see such a *big top* on an overbed table? 14¼ x 31¼ inches! 5-ply laminated base covered with tan or gray Zalmite. Resists damage by heat, cold, and spilled liquids.



Double-hinged center section can be raised from either side of table, permits full use of table either as a vanity or a book rest from either side of the bed.



The full width center section will hold a large magazine or a folded newspaper. Flat surface area at right is ample for articles in use when center section is raised.



The big stainless steel tray is ample for personal articles, writing materials, etc. Also available in porcelain enamel (F-884, F-888). Note the large size mirror.

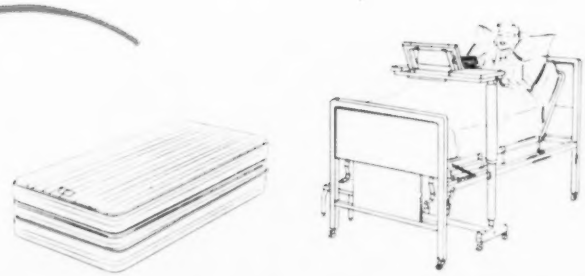
See your Hospital Supply Agent — Or write Simmons Company for details.

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Now! 2 great names give you 1 complete service

Something new and important has come upon the modern institutional scene. Royal, the top quality line in metal furniture . . . and Englander, the acknowledged leader in quality bedding, now, together offer you *one* complete service—one complete line of institutional furniture, available through either company. Get the full story from your Royal or Englander dealer today!



Englander, the rising star in the institutional picture with its famous Englander Mattress of Goodyear's Airfoam*, and exclusive Red-Line* Foundation, offers specially designed beds, mattresses and springs for every institutional need. Now, choose Englander and Royal . . . and you make a wise investment in long-range beauty, comfort, durability and economy!

THE ENGLANDER COMPANY, INC., Contract Dept., 1720 Merchandise Mart, Chicago 54, Illinois.

*TM The Goodyear Tire & Rubber Company
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For over 56 years, Royal has supplied the nation's leading institutions with the finest in metal furniture. That's because Royal offers the institutional buyer *more quality and extra built-in features!* Look to Royal and Englander to deliver the ultimate in modern design, longer-lasting beauty and economy in the institutional furniture field.

ROYAL METAL MANUFACTURING COMPANY, 175 North Michigan Avenue, Chicago 1, Illinois.





Tasty, Stable, Ready-to-use

Pediatric **Erythrocin** Stearate

TRADE MARK

(Erythromycin Stearate, Abbott)

ORAL SUSPENSION

A SWEET, cinnamon-flavored suspension with the cocci-killing effectiveness of ERYTHROCIN. That's *Pediatric* ERYTHROCIN Suspension. Little patients like it.

Pediatric ERYTHROCIN Suspension is ready for instant use. No mixing required. This new form of an effective antibiotic maintains stability for at least 18 months—whether or not the bottle has been opened. Prescribe odd or even ounces, as indicated.



ESPECIALLY INDICATED in otitis media, bronchitis, sinusitis, pharyngitis, tonsillitis, scarlet fever, pneumonia, erysipelas, pyoderma . . . when children are sensitive to other antibiotics or when the organism is resistant . . . when the organism is staphylococcus, because of the high incidence of staphylococci resistant to broad-spectrum antibiotics.

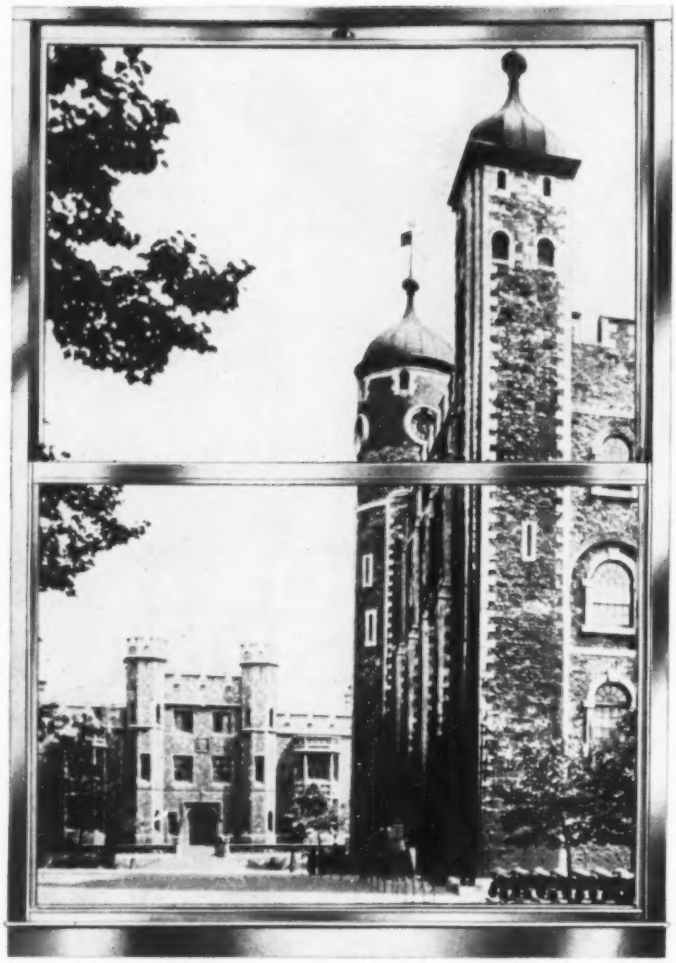
Like ERYTHROCIN Tablets, *Pediatric* ERYTHROCIN Suspension is specific in action—*less likely to alter the normal intestinal flora than the three broad-spectrum antibiotics.* Can be administered before, after or with meals. Pharmacies have *Pediatric* ERYTHROCIN Suspension in 2-fl. oz. bottles. Try it

Abbott

What?

Adlake

windows in the Tower of London?



It's too bad that William the Conqueror's master builders didn't have access to ADLAKE Windows when they began the Tower in 1078...for we believe that, had ADLAKE Windows been installed then, *they would still be in perfect operating condition today!*

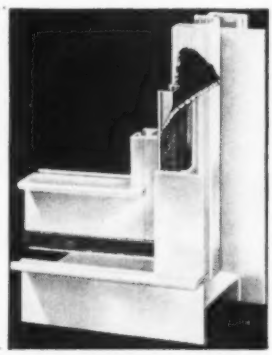
...for Adlake Aluminum Windows will last longer than the building itself, with no maintenance!

Literally, ADLAKE Windows pay for themselves by eliminating all maintenance costs except routine washing. Once installed, they'll keep their clean-cut good looks and easy operation for the life of the building, with no painting, scraping or other maintenance whatever! What's more, their woven-pile weather stripping and patented serrated guides give an ever *lasting* weather seal!

ADLAKE Aluminum Windows assure lifetime value, beauty and efficiency. Write for full details—you'll find ADLAKE representatives in most major cities.

Every ADLAKE Window gives these "PLUS" features

- Woven-pile Weather Stripping and Exclusive Patented Serrated Guides
- Minimum Air Infiltration
- Finger-tip Control
- No Painting or Maintenance
- No Warp, Rot, Rattle, Stick or Swell



Adlake 96th year of serving the transportation and building industries

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Small Hospital Questions

Dishwashing Secrets

Question: In machine dishwashing, how can we accomplish quick cleaning without having precipitation on china and glassware, or on the dishwashing machine and sink surfaces?—P.M.C., Calif.

ANSWER: The secret of proper dishwashing by machine is to not overload the unit with cleaning compound. Under normal conditions, about 4 ounces of cleaning compound to each 25 gallons of water provides the best results. Maximum cleaning will be obtained by keeping the cleaning solution at a temperarure of 130-140°F. Higher temperatures may cause certain food substances to "cook-on" the ware. The rinse water should be held at a temperature of 160-180°F. This will tend to make the dishes self-drying and will eliminate hand wiping. An important by-product is that control of temperatures of the cleaning solution and the rinse water, as indicated, will bring the dishes up from room temperature gradually and thus prevent breakage.

There isn't any dishwashing compound on the market, whether used for hand cleaning or in mechanical dishwashers, that will perform equally well in every locality. Water conditions, such as soft, medium or hard, govern the type of material needed.

The best way to obtain the most effective and economical dishwashing compound is to contact reputable manufacturers who specialize in all phases of cleaning and related operations. They have experienced technical service representatives who will call, without obligation, and run tests to determine the detergent most suitable for each individual requirement.

Bacteria-Laden Wastes

Question: What is the best method for disposal of garbage and sputum of tuberculosis patients?—R.T.C., Va.

ANSWER: The U.S. Veterans Administration has had a considerable amount of experience in the disposal of waste from tuberculosis patients. V.A. recommendations require that if waste is to be disposed of by burying, 1 foot of cover should be provided and the area should be posted after use. Since this method immobilizes large areas of ground, most tuberculosis hospitals in the United States feel that incineration is the best method. For this, the U.S. Public Health Service recommends use of a large central incinerator for both garbage and sputum, supervised by a trained employe. This method affords better control than is possible when, as is sometimes done, smaller incinerators are provided for sputum disposal.

Physical Therapy Plans

Question: I am a member of the board of trustees of a general hospital here. We are planning on adding a new department for physical therapy. This may require an expenditure of $400,000 or $500,000, and my purpose in writing to you is to get some statistical data that may help us reach a decision as to whether a hospital department of this kind is needed, and whether such a venture would be profitable.—M.E.A., Colo.

ANSWER: It would seem that you could have a department of physical medicine and rehabilitation for less than the amount named. The number of such departments in small hospitals has increased rapidly during the past few years; hospitals of 50 or 60 beds are now operating such departments successfully.

Your administrator can get information on departments of rehabilitation and physical medicine from the hospital journals and libraries. We recommend especially a study on this subject which appeared in the 26th (1948-49) edition of the *Hospital Purchasing File,* on page R78.

It is impossible for an outsider to give accurate cost and potential income figures without a careful study of the area and the hospital's operations. However, the administrator and medical staff, working closely together, should be able to make an accurate forecast of these factors.

Informing Doctors

Question: How can we educate our doctors to assume part of their responsibility for financing hospitals? Also, by what methods can hospital trustees police abuse of Blue Cross services?—V.P., N.Y.

ANSWER: Of course, there are a few doctors on every hospital staff who are interested primarily in using the hospital, and not in helping it. Probably there is no satisfactory method of getting these staff members to take responsibility for support of the hospital program.

On the other hand, the great majority of doctors feel a sense of responsibility for the hospital and are willing to help if they are shown the way. Like other human beings, doctors are most interested in the things they know most about; hence the first step in enlisting their support is to make certain they are informed about hospital activities and problems. This can be done through staff letters or bulletins, through periodic presentations by the administrator at medical staff meetings and, also, through systematic attendance by staff representatives at hospital board and committee meetings.

The answer to the second question, about "policing" abuses of Blue Cross service, emerges from the answer to the first question. Since abuse of Blue Cross service is an important problem in hospital finance and operation, this subject will naturally come up for discussion—either by the administrator at a meeting of the medical staff or by administrator and trustees at meetings which representatives of the staff are invited to attend. While careless use of Blue Cross privileges can probably never be eliminated completely, many hospitals have found that the better the doctors understand the relationship of hospitals and Blue Cross, and the importance to the hospital of eliminating unnecessary or prolonged services for Blue Cross patients, the more effectively overuse can be cut down.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.



In room 303, the patient only needs a 70° temperature since he is nearing full recovery and is ready to be discharged. Because this hospital has Individual Room Temperature Control, it's possible to supply the right temperature for each patient's condition.



In room 403, the room above, the Honeywell Hospital Thermostat is set at 78° to help the recuperative process of this patient, who suffered shock in an accident. With a thermostat in each room, physicians can prescribe the exact temperature each patient needs.

A mark of a modern hospital is a thermostat in every room

When a hospital has this feature – Individual Room Temperature Control – physicians can prescribe the exact room temperature needed to speed the patient's recovery. This can be done only if a hospital has Individual Room Temperature Control. No other method can compensate for the varying effects of wind, sun, open windows and other variations of internal load in each room.

That's why it's so important to consider Individual Room Temperature Control if you're planning to build or modernize your hospital. Of course, the most economical time to install this modern system is when the hospital is being built. For, contrary to most beliefs, Individual Room Temperature Control is not expensive – for most installations will cost only between ½ and 1% of the expenditure per bed.

For complete facts on Honeywell Controls for your hospital, call your local Honeywell office – there are 104 in key cities throughout the nation. Or for literature, write Honeywell, Dept. MH-10-95, 351 E. Ohio St., Chicago 11, Ill.



First thermostat specially designed for hospitals!

You get *all* these features only on a Honeywell Hospital Thermostat:

"Nite-Glowing dials" permit inspection without disturbing patients.
Magnified numerals make readings easy to see.
New Speed-Set Control Knob is camouflaged against tampering.
Air-operated: requires no electrical connections.
Lint-Seal insures trouble-free, dependable operation.

MINNEAPOLIS **Honeywell**

First in Controls



Modernize Your Hospital With Pittsburgh COLOR DYNAMICS To Get These 4 Important Benefits • • •

- aids convalescence
- relieves eye fatigue in operating rooms
- increases efficiency of nursing staff
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WHITEHALL RESIGNS

Albert V. Whitehall, director of the Washington Service Bureau of the American Hospital Association and a member of the A.H.A. staff for the last eight years, has resigned to accept an appointment as executive director of Washington Hospital Service—the statewide Blue Cross plan with headquarters at Seattle. He will take up his duties there Jan. 1, 1954.

ECONOMY RULE

The Eisenhower administration is not through economizing. And there are uneasy days ahead for the people who run the federal government's various hospital programs. The economists and economizers find Uncle Sam's hospital and medical care activities inviting fields for many reasons, but mainly because they cost a billion dollars a year and weave in and out through a score of departments. There is no unified control, except what the budget bureau attempts to exercise by resting a heavy hand on the money box while it asks a few questions.

During the first part of the year the President's superbookkeepers dug deeply into management practices and insisted on saving a large amount of cash. Whether they promoted efficiency or drained off life blood depends on whether it was your program or someone else's getting the treatment. At any rate, they did keep in the federal till hundreds of millions of dollars that otherwise would now be spent or at least be beyond recall.

During the late—and scorching—summer weeks in Washington, the budget bureau experts took a breather. Now they are again deep in statistics and charts. This year they have an advantage. This is the first time the Eisenhower team has been in the game from the start; last year the Truman administration did the preliminary work. True, a smaller Eisenhower budget was prepared later, but the people now working on the books had no chance last year to start gathering up the loose ends before Congress was under way.

In hospital operations, the economizers are interested in learning more about:

1. **How far Veterans Administration** should go in accepting nonservice-connected hospital cases as indigent, when there is evidence they can afford private hospital and medical care.

In Congressional hearings last spring budget bureau officials went as far as they could to point out that the country was inviting economic disaster by continuing the present free-and-easy policy of caring for veterans with nonservice conditions.

House veterans' affairs committee also wants to put some check on V.A. in this connection, and the American Medical Association has come out flatly against the present policy.

2. **The number of military doctors** assigned to care for dependents of military personnel. A Defense Department directive requires that the ratio of doctors to troops be reduced to three per thousand by next July 1. With this weapon, the budget bureau can make a closer check on what the army, navy and air force intend to do with their physicians. Although the budget bureau has no direct control over military hospitals or hospital construction, it can, with the directive in mind, insist that the services avoid hospital expansion where most benefits would go to wives and families.

SERVICEMEN'S DEPENDENTS

A Defense Department committee is at work drawing up a bill to carry out the recommendations of the Moulton Commission on Dependent Care. The commission last year recommended that (a) dependents be redefined and dependent care be redefined and made uniform for all the services; (b) qualified dependents be given care by private physicians and hospitals where they can't be handled by military hospitals, and (c) the three services straighten out their medical bookkeeping, so the costs and probable costs can be determined at any time.

3. **The responsibility of** the federal government for care of merchant seamen. This question is now up for decision; there is a possibility that this cost will be passed off on the steamship companies or the unions.

SEAGOING PATIENTS

Although the budget bureau and the Department of Health, Education and Welfare have worked well together in the economy harness—Secretary Hobby even defending bureau cuts before Congress—there is at least one indication that the cooperation has been stretched too far. It involves the bureau pressure, already mentioned, to eliminate free care of merchant seamen.

Relations between the bureau and executive departments are strictly confidential; under the personnel code any employe may be discharged for discussing budget bureau correspondence anywhere outside a congressional hearing. During the spring and summer **the bureau twice requested** the Department of Health, Education and Welfare to prepare a budget without including cost of caring for merchant seamen. **The news** of what was happening leaked out. This gave Secretary Hobby an excuse for making a public statement on the question.

The secretary admitted that she was under bureau pressure to cut out care of the sailors. Then she said she

couldn't do that without estimating the cost of other beneficiaries also cared for free by Public Health Service in the marine hospitals.

Such estimates were being prepared, she said, and the information would be turned over to the bureau. It was a neat bit of maneuvering by the lady secretary, and it wasn't at all what the budget bureau had expected.

Now Secretary Hobby will break down the whole picture of what it costs to run all the P.H.S. hospitals, and who benefits. Her suggestion is that possibly the best procedure is for the other government departments involved to start paying P.H.S. for their patients.

Merchant seamen make up about 40 per cent of the marine patients. The others are coast guardsmen and federal employes injured or taken ill while on duty. The Commerce Department would be responsible for the guardsmen and all other departments would share responsibility for the latter. But Mrs. Hobby also will present the cost of running the two P.H.S. hospitals for narcotic addicts at Lexington and Fort Worth and the Carville, La., hospital for lepers. A high percentage of the patients at Lexington and Fort Worth would be prisoners, charges of the Justice Department. Cost of caring for the lepers could not be assessed against any other federal department.

While not a large operation in comparison with Veterans Administration or the military services, the 16 marine hospitals nevertheless handle a substantial patient load. Last year it averaged 5500 per day.

P.H.S. officials are proud of their low average patient cost in the marine hospitals, and maintain that if other arrangements are made for the future the cost will be greater, with no guarantee that the service will be any better.

If merchant seamen patients are removed, P.H.S. plans to close down all the marine hospitals. This would throw back the coast guardsmen and government employes on the other departments. A completely new hospitalization program of some sort—government or private—would have to be set up. So Mrs. Hobby's report, highlighting the cost of a new service, may settle the whole affair. The budget bureau may well decide that in the end there wouldn't be enough saving to justify the loud and long argument it would provoke all over the country.

PHYSICIAN SHORTAGE

Many doctors are beginning to watch Secretary Hobby with unusual concern, particularly to see if she believes, as did her predecessor, Oscar Ewing, that the federal government should do something about the alleged shortage of physicians.

Their interest was stirred by her talk at the American Hospital Association meeting, where she suggested that perhaps we weren't turning out enough doctors to keep up with population increases. The key phrases: ". . . Someone living in a small town may have no doctor for 50 miles or more. . . . We need to face the fact that we need more doctors of all kinds. . . ."

Nowhere in her talk was there reference to the fact that medical colleges are increasing their enrollment at a relatively rapid rate, nor was there a suggestion that today's doctors, with the help of more and better nurses and more and better hospitals, are doing more and better work per hour.

Later, Mrs. Hobby talked at the dedication of a Louisville hospital. She covered somewhat the same territory in her remarks, but this time there was little or nothing to alarm the doctors. One answer might be that Dr. Chester Keefer, her special assistant for health matters, was not on the job at the time of the A.H.A. talk. He was on the job at the time of the Louisville talk and presumably had an opportunity to look over a draft of her talk before it was delivered.

MINE WORKERS

The annual report of the United Mine Workers Welfare and Retirement Fund is evidence that the miners' hospital and medical care program is prepared to dig itself deeply into the communities.

The report discusses liaison committees appointed by state medical associations for the purpose of "advancing the standards of medical care where needed, developing and maintaining good cooperative relationships between practicing physicians and the medical administrators of the fund, and arriving at satisfactory solutions of various problems that arise."

So far, these committees generally have been forums where doctors talked to doctors. Now, U.M.W. indicates, it is prepared to bring in other elements of the community. The report states: "These committees are due to be formalized and strengthened with the probable inclusion of university and state health representation, along with that of other groups, to ensure a better total picture of the medical care problems within the state."

Relations between the fund on the one hand and private hospitals and physicians on the other have not always been harmonious. With the U.M.W. started on its large hospital building program, it may feel the need of broader non-medical support at the community level.

NOTES:

Helped by a $125,000 grant from Public Health Service, the Commission on Chronic Illness has begun an extensive survey of chronic illness in Baltimore. Availability of hospital and nursing home beds will be one of the points to be studied.

A definite slackening in demand for physicians has been admitted by the military services; the army, in fact, found itself with an oversupply of about 500 late in the summer and turned them over to the navy and air force. There will be no additional calls for several months, and possibly not until next spring.

Military medical units in Korea are assisting the Koreans in rebuilding and restaffing hospitals and training personnel; however, work is to be on a "voluntary" basis, and it is not supposed to affect the ratio of physicians to troops.

The Modern Hospital
OCTOBER 1953



LOOKING AROUND

One-Hutch Ward

HOSPITAL administrators and women's auxiliary chairmen all over the country have been congratulating themselves for decorating their pediatrics wards with those cute, colorful decals of animals, Mother Goose and comic strip characters. Fact is, however, these people aren't keeping up with the times at all. To liven up the ward and keep the kiddies occupied, the latest thing is a product of the rare imagination of Colin MacLean, the hospital decorating and furnishing man: Cage of live rabbits.

Conspiracies

WE RECEIVED a letter a few weeks ago accusing us, on the basis of something or other we had printed here, of taking part in a conspiracy to give hospitals control of the medical profession. It was a long, involved letter, from a doctor who saw, or thought he saw, a purposeful plot in an unrelated series of events and statements most of which, as it happened, we didn't even know about. As a matter of fact, we are on distant, if not actually chilly, terms with the party named by the doctor as our principal partner in the conspiracy.

Moreover, the doctor's charge is an absurdity on the face of it, because the medical profession can't be controlled by anybody in the sense that a dictator may control a nation, or a general an army. The medical profession is an abstraction, meaning different things at different times but always referring in one way or another to the nation's 200,000 doctors of medicine, who conduct their practices in 48 separate legal jurisdictions and, to a limited extent, in some 9000 institutions. The trustees, or owners, of a single institution may, the courts have ruled repeatedly, establish regulations governing the conduct of medical practice by physicians within the institution; outside it, they can have no authority. Thus the conditions for a conspiracy such as the one charged are absent, even if the intent were present, which it isn't.

But the tragedy of the doctor's letter, it seems to us, is neither that he has falsely accused us of conspiring against his profession, or that he misunderstands the nature of professional freedom. The tragedy is that he has fallen victim, as have so many others throughout our society, to what a psychologist friend of ours has called the conspiratorial outlook on life—the fearful compulsion to find a sinister motive for every act and to weave isolated phenomena together, with a web of presumed evil intent, into a gigantic plot. In the conspiratorial view, the efforts of a troubled administrator or trustee in Massachusetts to establish regulations which will protect hospital patients from a fee-happy surgeon, and the efforts of an administrator in Ohio or Montana to use revenues from a medical department to make up deficits incurred elsewhere, and the reports of these problems and attempted solutions in a journal published in Chicago, are linked together and take on the shape of a huge conspiracy to control all the acts of 200,000 doctors in 48 states.

The true nature of conspiracy was stated in explicit terms in 1949 by Judge Harold R. Medina in his charge to the jury in the trial of 11 Communist leaders charged in the U. S. District Court of New York with conspiring to overthrow the government of the United States by force and violence, in violation of the Smith Act. In a statement that should be required reading for Americans in all walks of life today, Judge Medina said: "A conspiracy may be defined as a combination of two or more persons, by concerted action, to accomplish a criminal or unlawful purpose, or some purpose not in itself unlawful or criminal, by criminal or unlawful means. The gist of the offense is the unlawful combination or agreement to violate the law. . . . Proof concerning the accomplishment of the objects of a conspiracy is the most persuasive evidence of the existence of the conspiracy itself."

By this or any other reasonable definition, there isn't any conspiracy to control doctors unlawfully, nor is there any shred of evidence that they are being controlled except by the established laws of the commonwealths and by voluntary agreements binding only on those who enter into them and observe them voluntarily. The individual physician is always at liberty to practice as he pleases within the law. When he joins a group such as a hospital staff and accepts the disciplines as well as the benefits of staff organization, he isn't a victim of anybody's attempt to infringe his freedom. Rather, he is giving active expression to the principle that places the interests of his patients ahead of his self-

interest. This is the righteous principle that has distinguished doctors of medicine since the time of Hippocrates, and the only conspiracy that could hurt doctors would be a conspiracy to subvert the principle.

Fake

HOSPITAL down in Kansas discovered the other day that the brisk, capable young man who had served several months of a residency in obstetrics was actually an impostor. He'd never been to medical school at all, it turned out. Used phony credentials, and the name of a man who is a licensed medical graduate. Before going to Kansas he had "practiced" in a small town in Illinois, where, according to an A.M.A. dossier, "he is alleged to have conducted himself as a physician in such a manner as to gain admiration from his professional associates."

By the time the Kansas people found out about him, the resident had scrammed. Went to the Eastern office of a popular weekly magazine where he tried, unsuccessfully, to sell his story to the editor.

But he didn't get away after all. Last month, he was picked up by the F.B.I. and shipped to San Antonio to stand trial for false statements made in an application for status as a contract surgeon at Fort Sam Houston. Apparently, the editor and the government didn't admire him as much as the doctors and hospital did. Probably a moral there somewhere.

Silver Lining

HOSPITAL publicists like to make bright copy of the fact that it took 30 days in the hospital to cure Grandma's pneumonia, whereas today's miracle drugs have the pneumococci hanging on the ropes in a matter of a week or less. This circumstance, they point out, makes our $20 a day hospitalization a stand-off with Grandma's bills of $5 a day—and we have the added advantage of getting well most of the time. It's a good story, and in recent years it has sent many a hospital patient on his way reassured, if not rejoicing.

According to the latest bulletins from the outer frontiers of science, however, this happy state of affairs may not last forever. There is a possibility, at least, that we may look back on this antibiotic era as a short, victorious skirmish in a long, uphill battle which may yet be lost. At the annual meeting of the British Medical Association this year, a number of doctors reported apprehensively that the bugs are biting back at the drugs. A general



practitioner from Manchester, for example, said his patients had developed strains of bacterial infection resistant to penicillin, streptomycin, chloromycetin, aureomycin and terramycin. A dermatologist from Cornwall said antibiotic creams and salves, which were slapped on like mortar not long ago for everything from barber's itch to mosquito bite, were no longer "of outstanding value in dermatology." Another doctor reported gloomily that 60 per cent of staphylococcal infections are now penicillin resistant. The discouraging tone of these bulletins could probably be put down as nothing more than one would expect under socialized medicine if it weren't for a disturbing fact: The same fading hopes have been noted in our own clinical journals.

It seems unthinkable that we should have to throw up our hands and go back to treating infection as it was done in the days of saddle-bag medicine, and we refuse to accept defeat. We have faith that medical science and medical industry will be equal to the challenge and will lay down a new miracle for every hope that vanishes. If the scientists should lose out, however, we can still fall back on the publicists, who will make failure look like triumph. Man, dig these crazy new poultices!

Hosp. Adms.

WE HAD occasion not long ago, during the course of a minor journalistic errand, to refer to "Who's Who in America," the outsize compendium of biographical information on the great, the near-great and notable men and women of our society, whose lifetime achievements are compressed into a few tight lines of Who's Who shorthand. Our errand completed, we started hopping idly around among the pages of Who's Who, as a man sometimes does when, after looking up *analgesia*, say, in an encyclopedia, he spends the next half-hour reading up on *analcime*, a mineral of the zeolite group, and *analysis situs*, a refinement of Euclidean mathematics. We fell to wondering, then, how hospital administrators fared among the statesmen, educators, attorneys, businessmen and others of Who's Who stature, or displacement.

Well, they fared pretty well, if you want to know. A lot of them are in there, for one thing, and they look pretty good alongside your average senator, manufacturer, or radio commentator. A Who's Who hospital administrator, it turns out, is likely to have had several appointments as asst. adm. or dir. of various hosps. He has been a mem. of numerous bds. and coms., and has been sec. or chmn. of several of these. He has probably been pres. or mem. exec. com. of hosp. assns., prof. of hosp. adm. or lec. in at least one univ., and, invariably, he has contrib. to hosp. mags.

As far as we pursued the matter, anyway, the champion chmn., pres., sec. and mem. among hosp. adms. is Dr. Robin C. Buerki of Detroit, whose biography, for all the editors' efforts at abbreviation, adds up to an impressive 67 lines in Who's Who. Not far behind is Boston's Dr. Charles F. Wilinsky, with 58 lines—a score which puts him a mem. or two ahead of President Eisenhower, who has 57 lines.

Other high scorers among the adms. we looked up were Dr. Edwin L. Crosby, dir. Jnt. Com. Accred. Hosps., whose 37 lines looked big alongside another Crosby, Bing, who, like vice pres. U. S. Richard Nixon, has 14 lines; Dr. Basil C. MacLean, who will add a line to his 35 in the next edition when Who's Who reports that he rec. 1953 Award of Merit, Am. Hosp. Assn.; and Joseph G. Norby, past pres., who tied past pres. Harry S. Truman at 26 lines.

Evidence of a paper-saving conspiracy between the editors and the subject showed up, we thought, in the biography of George Bugbee, whose scant 10 lines barely make note of the fact that he was born, grad. U. of Mich., married, and has been exec. dir. Am. Hosp. Assn. since 1943. As a matter of fact, it's probably a good thing that Bugbee's biography omits all the bds. and coms. he has served as mem., sec. and chmn. There wouldn't be rm. in the bk.

THE ISSUE AT INDIANAPOLIS

What happens when the administrator and staff members clash publicly over control of surgery? A reporter here examines the evidence in the dispute at St. Vincent's



ARTHUR J. SNIDER
Science Editor, Chicago Daily News

IT WAS inevitable the issue would be joined somewhere, sometime. Needed only was the right combination of clashing convictions and prominent personalities. These reagents fatefully came together in St. Vincent's Hospital, Indianapolis, and the resulting explosion boiled up the unequivocal question: "Who has the authority to pass final judgment on the professional competency of a hospital staff doctor?"

One could scarcely contrive a more dramatic set of ingredients for a controversy. A resolute hospital administrator was pitted against the powerful Indianapolis Medical Society. A high ranking surgeon was the storm center. Influential forces rallied to one side or the other. A public normally apathetic about internal hospital affairs was fired to a feverish pitch of street-corner debate.

The smoldering dispute broke out of the brick-walled confines of St. Vincent's on June 17 when the council of the medical society circularized the full membership for approval of a resolution charging the hospital administrator, Sister Lydia, with acting in an "arbitrary and discriminatory manner" in dismissing three staff surgeons for allegedly performing unnecessary surgery.

The three were Dr. Karl R. Ruddell; his son, Dr. Keith Ruddell, and an associate, Dr. Ray Tharpe.

Here was grist for the front page mill. Dr. Karl Ruddell, at 66, was probably the state's most widely known surgeon. He was a former president of the Indiana State Medical Society and the Indianapolis Medical Society. He was a staff member at St. Vincent's for more than 40 years and a highly respected attending man at some 32 hospitals in Indiana. He was one of the most active surgeons in the United States. From 1943 through 1952, by his own records, he had performed 16,104 major operations—1600 operations a year, or about 5.2 per working day.

"After a lifetime of devotion to the service of others, Dr. Ruddell, in the sunset of life, has been struck with a brutal psychological blow," said one doctor in commenting on the dismissal.

Doctors throughout Indiana rushed to the defense of their associates. The Hamilton County Medical Society passed a resolution expressing confidence in them and indignantly accusing Sister Lydia of "seriously abusing her inherent authority." Each local medical society was urged to follow suit.

The Indiana Academy of General Practice, with a membership of 600, adopted a similar resolution and used the occasion to take a pot shot at an old foe, Dr. Paul R. Hawley, director of the American College of Surgeons. Hawley, avowedly an innocent bystander, was caught up in the cross fire when his letter characterizing Sister Lydia's action as "striking a great blow for the right" was quoted in the press.

The letter had been sent to the Most Rev. Paul C. Schulte, Catholic archbishop of Indianapolis, who released it as part of his own statement backing Sister Lydia's action. "Sister Lydia has my support . . . and my admiration for the fortitude and courage with which she has met the abuse and the silence with which she has borne the odium of carrying out a most disagreeable duty," the archbishop said.

Sister Lydia, a tall, erect woman with a firm chin, issued her first statement at a press conference on June 23, seven weeks after the surgeons' separation from the staff took place and six days after it was revealed.

Flanked by Church and hospital leaders, she pointed to a black notebook. The story, she said, was contained in its pages—a medical audit showing deficiencies in surgery.

There had been "rumors," she related, of unnecessary surgery at St. Vincent's. The executive committee of 14 doctors had unanimously adopted the suggestion of an audit. Dr. Henry G. Farish, a private auditor, was engaged to review records from Dec. 1, 1951, to Nov. 30, 1952.

"The audit confirmed my worst suspicions," Sister Lydia said. "The weaknesses and abuses found were confined to surgery. Relatively few men were involved."

She took the audit to the Very Rev. J. J. Cronin, director of the Western Province of the Daughters of Charity, which operates St. Vincent's; to Sister Catherine, visitatrix; to Archbishop Schulte. Subsequent actions of Sister Lydia were in accord with the directives of these superiors.

She consulted with Dr. Edwin Crosby, executive director of the Joint Commission on Accreditation of Hospitals. He urged delay until Dr.

Farish's findings could be checked.

When Dr. Robert Myers, examiner for the Joint Commission, orally corroborated the audit on April 29, Sister Lydia deemed it unnecessary to wait for a written report. She promptly called in the three surgeons and gave them a choice of resigning or facing an examination by the executive committee. Neither then nor later, however, were the detailed findings of the investigators made public by the hospital.

"Within 24 hours, all three resigned," Sister Lydia told The MODERN HOSPITAL. "I regretted it was publicized by others. It was our wish that any disciplinary action was to be confidential to protect the reputation of the individual doctors. At no time have the doctors been named by St. Vincent's Hospital. The audit itself was done in code and the names were not known to the executive committee of the staff."

A day after the resignations, the wheels began turning in Suite 1022 of the Hume Mansur Building in downtown Indianapolis. The council of the Indianapolis Medical Society had before it a complaint filed in behalf of the three surgeons.

"Upon receipt of a complaint," the official statement said, "the council undertook to exercise one of its functions, which is the protection of physicians' rights in such matters. This obviously required the council to make an investigation. . . . [It] appointed a committee of five physicians charged with endeavoring to ascertain the facts and to try to arrive at an equitable and just solution of the problem.

"The committee met with the administratrix on May 12, 1953. At this meeting the request was made that the hospital administration allow the committee to review the records of the three physicians covering the period from Dec. 1, 1951, to Dec. 1, 1952, and presented a letter from the doctors involved in which consent was given for review of the records. These were the records on which the hospital administration based its demand that the three doctors resign. The committee was refused permission to review these records. Having been denied review of the hospital records, the committee then spent many hours in review of the office files and the records of the three physicians.

"After serious and lengthy study of the committee's report, the council unanimously found as follows:

"1. No evidence was found to support the statement of the administratrix that the physicians in question are professionally incompetent.

"2. The administrative head of St. Vincent's Hospital acted in an arbitrary and discriminatory manner.

"3. No official consultations or recommendations were made by the staff, society or other official groups of doctors of the hospital."

It was not Sister Lydia's first embroilment. There were stormy days shortly after she took over the position in 1948. She found the obstetrical department badly overcrowded and the state health department unhappy about it. She withdrew the privileges of about 170 doctors carried on the courtesy staff. It was to be a temporary measure, she explained, until the overcrowding could be eliminated. The move created a furore. The Indianapolis Medical Society charged Sister Lydia was fostering a "closed" hospital. In the forefront of the battle, according to doctors' reports, was one Dr. Karl R. Ruddell.

Sister Lydia was compelled to rescind her action when it was discovered that most of the 170 actually had active privileges on the staff. Sister blamed it on an error in the records department. Since then, the obstetrical department has been enlarged.

"And there you have the reason behind Dr. Ruddell's dismissal," one physician said. "It stems from her spirit of vengeance." This view baffles Sister Lydia, who says she wasn't aware that Dr. Ruddell had anything to do with the 1948 affair.

On another occasion, later in the year, Sister Lydia decided for the purposes of better hospital administration to reclassify staff appointments into active, associate, courtesy, honorary and consulting—in keeping with American College of Surgeons recommendations. Actives were not to exceed one member for each four beds. Again the cry, "closed hospital," went up from the Indianapolis Medical Society. The St. Vincent's executive committee was summoned before the society's ethics committee. This led to a joint meeting early in 1950 between the hospital administration, the American Medical Association, and the Indianapolis council. It resulted in a victory for Sister Lydia. She made her decision stick. Residency approval in general surgery, internal medicine and orthopedics followed.

By this time it was clear to the medical profession that here was a hospital administrator who was going to stand her ground in any dispute. "Sister figures she had nothing to lose," a friendly staff doctor told The MODERN HOSPITAL. "Unlike other hospital administrators who fear for their jobs, she has nothing to lose. She has no family to support. She is determined to carry through her deep and abiding convictions.

"The truth is," the doctor continued, "some old guard doctors were running the hospital before she came in. We had an executive committee, a surgical credentials committee and a professional standards committee from time to time, but these men were so harassed, their livelihood in Indianapolis was threatened.

"Just as soon as new doctors would join the house staff, they were taken aside and indoctrinated against both the administration and the surgeons in charge of the educational program. The teaching group was so ridiculed and belittled, the house staff wouldn't attend conferences. Sister is changing all that, and a lot of men don't like it."

The most recent episode was a showdown. Seldom has a hospital administrator been so calumniated. A petition signed by 150 Indianapolis nurses condemned Sister Lydia's action as "unfair, unjust and unwise." Tributes to Dr. Ruddell appeared in the press. A doctor said his dismissal was a step on the way to socialism. A woman wrote that Dr. Ruddell once treated her for cancer and never charged her. A nurse wrote it was the doctor who has the right to decide what to do to restore a patient to health. Others pointed out Dr. Ruddell was called in on difficult cases constantly throughout the state and did major surgery others would not attempt. According to one doctor's report, petitions protesting Sister Lydia's action have been signed by more than 8000 people over the state.

But Sister Lydia was not without her supporters. A pharmacist wrote he was taking a "man on the street" poll in his drug store and 882 of the first 900 persons asked endorsed the stand taken by Sister Lydia. One Indianapolis resident praised her for her "will power, fortitude and courage in standing up to the austere medical profession."

"I am in business, contacting a lot of people," another wrote, "and I can truthfully say that 95 per cent of the population is behind Sister Lydia."

Three prominent physicians of Nashville, where Sister Lydia formely headed St. Thomas Hospital for six years, testified to her "brilliant record" there.

A native of Illinois, Sister Lydia has been in hospital work since 1917. She received a bachelor of science degree at Northwestern University in 1916 and a master's degree in 1929. She is a registered nurse, a fellow of the American College of Hospital Administrators and a member of the executive board of the Catholic Hospital Association.

The entanglement with the Indianapolis Medical Society was just the beginning of Sister's troubles in the Ruddell affair. Having chosen to clean up surgical deficiencies, the hospital was promptly slapped with a "provisional" accreditation, put on a year's probation and confronted with the loss of approval as a teaching hospital for residents and nurses.

The deficiencies cited by the Joint Commission were:

"1. Lack of adequate control of the surgical work done in the hospital.

"2. Excessive removal of normal tissue.

"3. Lack of a recorded thorough review and analysis of the clinical work done in the hospital.

"4. Excessive anesthesia death rate.

"5. Failure to record essential physical findings in the medical records."

Sister Lydia released the Joint Accreditation report which showed the following tabulation:

Department	Maximum Possible Pts.	Points Earned
Physical plant	20	17
Medical staff org.	200	157
Administration	35	35
Medical records	125	93
Clinical laboratory	95	95
X-ray	50	43
Nursing service	90	90
Dietary	25	25
Medical	50	39
Surgical	100	77
Obstetrical	75	58
Anesthesia	40	28
Pharmacy	20	20
Outpatient	20	14
Medical social service	20	20
Totals	965	811

"Up to this point, the hospital had earned sufficient points for full accreditation," Sister Lydia recounted. "But because of the deficiencies of a small percentage of the members of the surgical staff, the hospital was penalized 203 points, which is equal to 25 per cent of the points earned. This brought the final score for the hospital down to 63 per cent. Ratings of 74 to 60 entitle the hospital to provisional approval. In order to obtain full approval, the hospital rating should range between 75 and 100 per cent."

Sister Lydia and the executive committee of the staff have taken steps to correct the evils with the expectation that the hospital will be back in good graces within a year. A new surgical tissue committee has been appointed and a periodic medical audit will be made.

But the battle with the medical profession is not yet resolved. The Indianapolis Medical Society, by a vote of 433 to 154, endorsed the action of the council in supporting the dismissed surgeons and terming Sister Lydia's action "arbitrary and discriminatory." No further action is planned at that level. But a young war veteran is carrying on. He is Dr. Joseph Walther, 40, an internist and a friend of the three men. He is also a son-in-law of Dr. Karl Ruddell.

"My relationship to Dr. Ruddell has no bearing," Dr. Walther told The MODERN HOSPITAL. "Dr. Ruddell has wished to drop the whole matter. I am going contrary to his wishes to continue the fight because there are principles involved here that have a bearing on the future course of medicine."

What are the principles?

The first, says Dr. Walther, is the propriety of having a hospital board of individuals who are nonprofessional in the position of arbitrary power which allows it to dismiss physicians from the staff, with or without cause.

It is a philosophical truth, he contends, that dictatorial powers ultimately lend themselves to abuse, to the detriment of the public. "No hospital can discharge its responsibilities to the community in which it exists (usually tax free) unless there is an equal balance of power between the nonprofessional and professional governing bodies," Dr. Walther adds.

"It is a contention of most of the physicians at a grass roots level that professional skill is a highly individualized matter. Ability speaks for itself, and the evaluation of a professional person's worth can be done properly by individuals of like skills."

The second principle, says Dr. Walther, involves the propriety of the "so-called 'hospital audit' serving as the basis for determining the professional competency of a physician. An audit is based on case records which may not be complete and on reports from the pathological laboratory of the hospital which may be authentic but also may be in error. The human factor enters this question," says Dr. Walther. "Is the pathologist or the person keeping records less human than the surgeon? Medicine cannot be reduced to the matter of the accuracy of an audit because there are other variables that enter into the picture." In fact, Dr. Walther added, the council's investigating committee had found "numerous errors in diagnosis on the part of the hospital's pathologist" in the records of the three physicians.

Sister Lydia, on the other hand, holds that the hospital's governing board, acting through its administrator, bears full moral and legal responsibility for patient care—"and that includes safeguarding them against the incompetent doctor." This responsibility cannot be delegated to the medical staff.

Second, she emphasizes, medical staff membership is a privilege, not a right. In keeping with the first principle, she says, the hospital administration has the right to pass on that membership.

And finally, a medical association is not the hospital's governing body nor is it the hospital's accrediting body.

What of her "dictatorial, arbitrary" manner of acting in asking for the resignations of the surgeons? Sister Lydia admits she acted without consulting the executive committee. But she felt she had every legal right to do so. Furthermore, she wanted to protect the members of the executive committee in their professional relationships in the community. She wanted to make real leadership again possible among members of the medical staff. If further friction developed over the men involved, it would have been difficult.

But lest there be any doubt about the medical executive committee's feelings in the controversy, Sister Lydia pulled out a resolution, signed by Dr. Don Bowers, president of the committee, which stated:

"The executive committee of the staff of St. Vincent's Hospital has unanimously approved the conduct of Sister Lydia and the board of trustees as being in the best interests of St. Vincent's Hospital and the public."

NURSES' NOTES COST MONEY—

So why not simplify them and economize?

JOHN H. GORBY
Administrator
La Mesa Community Hospital
La Mesa, Calif.

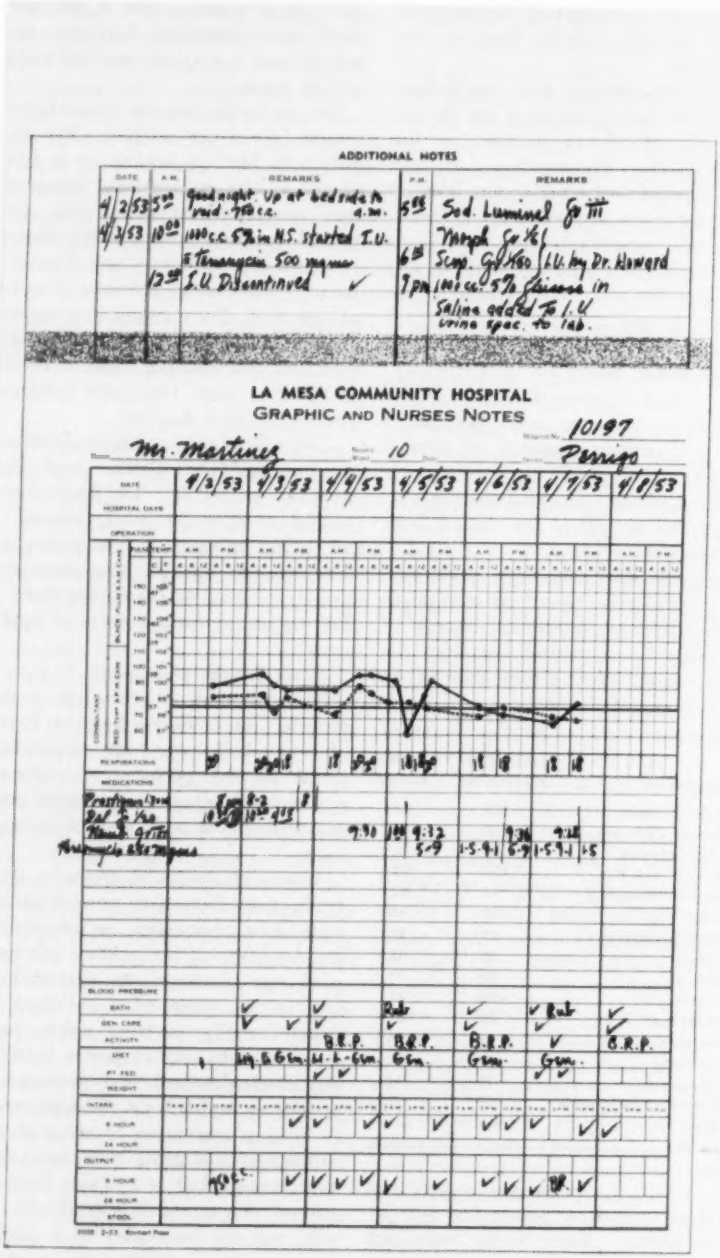
LUCIUS W. JOHNSON, M.D.
San Diego, Calif.

WHEN you talk with people who do professional audits of hospitals and with those who examine them for accreditation, you learn that they have one complaint in common. They say that they find entirely too many clinical records in which the only clue to the patient's age, sex, symptoms, diagnosis, progress and condition on discharge are in the nurses' notes.

If you bring this up for discussion in a group of hospital administrators you are likely to be slapped down with an impatient snort and the brusque demand: "Why should these be in the nurses' notes at all? Is she the one best qualified to observe and interpret these things?"

As you seek the answer to this one, your next step toward confusion is the query: "Exactly what should be in the nurses' notes?" By this time you have really achieved Grade A perplexity, for there seems to be no consensus on this point. Look at these conflicting points of view.

"Hospital Organization and Management," by Dr. Malcolm T. MacEachern (*p.* 602 *et seq.*) states: "The nurses' section of the record consists of the graphic chart, physicians' orders, orders for treatment, and record of treatment and symptoms. . . . The Nurses' Record of Treatment and Symptoms . . . is the nurses' report of what she has done and observed. As in the case of other forms there is an infinite variety in use, and in most cases there is an unnecessary repetition of entries recorded elsewhere. . . . It is not advocated that the nurse chart every symptom at the time of her observation."

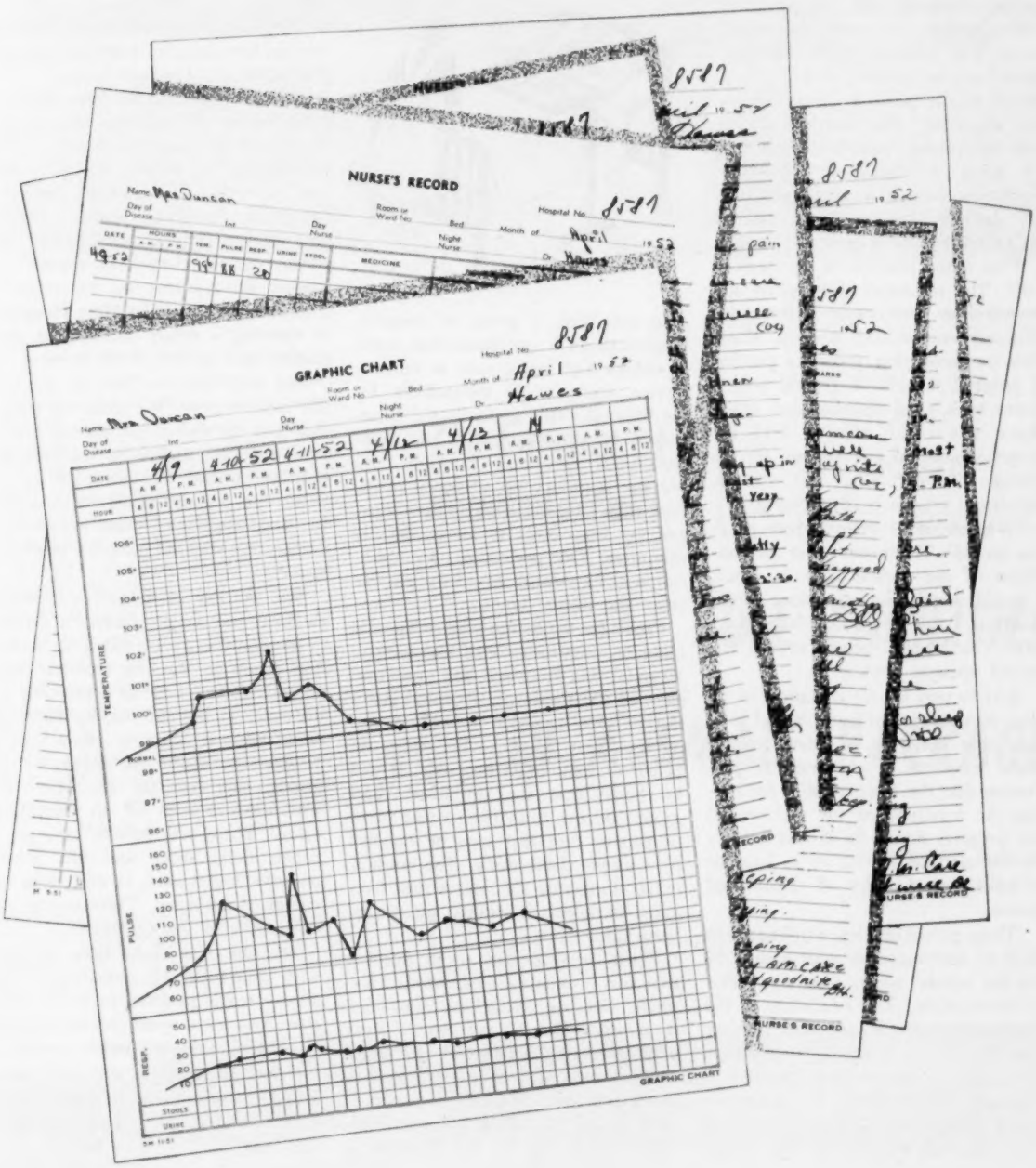


Above: Simplified form combining graphic chart and nurses' notes adopted by a group of West Coast hospitals. Section at top shows additional notes entered on back of form. Opposite Page: Number of pages formerly required to encompass this information.

In "Principles of Hospital Administration" by Dr. John R. McGibony (*p.* 477) under the heading, "Nurses' Notes," we find: "This is for the use of the nursing personnel in recording their observations. . . . Nurses' entries should be limited to information and observations concerning the patient's reactions, condition and significant items of care. Entries concerning routine care, such as bed baths, or observations that 'patient had a good night' add little to the record and should be omitted."

What do representatives of the nursing profession have to say regarding this age-old problem of nurses' notes. It is interesting to note the change in emphasis on charting as taught 25 years ago and in today's school. A director of nursing service (class of 1930) was asked her opinion of the proper content of the nurses' notes. She is one of the fine, upstanding, conscientious sort that you would like to have in charge at your hospital. Here is her reply:

"I was brought up with the fixed idea that the nurses' notes were to be a running diary of the entire 24 hour patient day and give a constan: picture of the patient's condition at any time. It was continually brought to our at-



tention that only by this means could the doctor intelligently diagnose and treat the condition."

One of the younger generation, a graduate of a large teaching hospital, gave this answer: "'We were taught to chart all symptoms, routine care, visitors and any item affecting the patient. This was to assist the doctor in following the progress of the patient."

The director of a school of nursing in a large urban hospital states: "Our student nurses are now taught to avoid routine comments and pay attention to the unusual. The number of respirations per minute, while routinely charted on the graphic, is not so important as any possible irregularity in their sequence. The charting of 'patient comfortable' seems to imply that the nurse is unable to determine whether a patient is comfortable or not. Isn't it obvious that a patient has 'no complaints' if none are noted?"

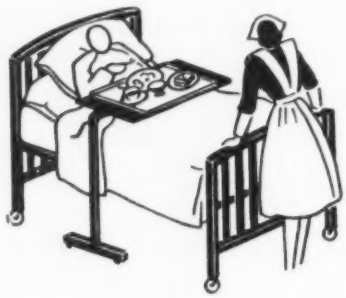
What is the position of the medical staff? The surveyors of hospitals for accreditation consistently find in the voluntary nonteaching hospital, along with the incomplete record, a paucity of progress records. A general practitioner with good training and experience was asked why he held his progress notes to one or two for an average four-day stay. His answer, perhaps, is singularly illuminating.

"Why should I write a daily progress record? The nurses cover the condition of the patient hour by hour; I would merely duplicate their work. Anyhow, I am busy with a large practice. You hospital people overdo this record business anyway."

A reduction of this statement to its least common denominator would indicate that there is sentiment among some members of the medical profession that the responsibility for noting the condition of the patient and his progress should be shifted entirely to the nursing service or at least be a joint responsibility of doctor and nurse.

These points of view emphasize the lack of agreement on what should be in the nurses' notes. One conclusion is inescapable. The education of the registered nurse is so costly in time and money that it is not good business or sound administrative practice to squander her services. If she spends time thinking up and writing down facts that are valueless or that should be entered by somebody else that time is wasted.

Nurses' notes cost money. Are they worth what they cost? If so, to whom? Who profits by them, the patient, the doctor, the nurse, the administrator, or the hospital? Or are we keeping records, at high cost and of dubious value, just as a salaam to tradition? With hospital costs as high as they are, and still climbing, these queries merit thoughtful consideration.



In the West a group of hospital administrators is convinced that some of today's high costs, such as nursing service, are partially controllable by the hospital. This group is the Community Hospital Section of the Association of Western Hospitals. Its purpose is to increase efficiency, maintain high standards of patient care, and yet keep costs to an irreducible minimum. One project was a simplification and condensation of the graphic chart and nurses' notes.

Credit for the design goes to Thomas Langdon, administrator of Hahnemann Hospital, San Francisco, and president-elect of the California Hospital Association. Mr. Langdon is well known on the West Coast for his efforts on behalf of community hospitals. It will be noted that the simplified chart groups on the front the routine items of patient care that may be handled by a simple check mark. The unusual, or anything that the doctor may have asked be noted, is entered on the reverse side.

There is space for seven hospital days and 12 separate medications. Hospitals that are using the simplified form report that 85 per cent of their admissions are handled with one single sheet instead of five to eight as formerly required. There is no scramble at 6, 2, and 10 o'clock "to chart." An additional feature for the physician is that his medical handling of the case is graphically portrayed at all times.

Many examples of the savings to be achieved could be given. Consider Case No. 1. It is of an average acute appendix patient who was operated on and stayed five hospital days. The record required one page of graphic chart and six pages of nurses' notes. Case No. 2 was similar except the patient was in for six hospital days. Pages required for the graphic and nurses' notes totaled *one.*

Compare the two cases. There is no information *essential to the doctor* that has been omitted from the record of Case No. 2. Although progress record on these cases has not been shown, it is worthy of comment that Case No. 1 with six pages of nurses' notes had exactly two entries under "progress." Case No. 2, the six-day patient, had seven "progress" entries. These two cases were not hand-picked to prove a point. They were selected at random. But it is true that the progress record of patients at La Mesa Hospital is showing a steady increase in the number and quality of the entries.

The new form has been in use for five months now. We make no claim that it is the end of all nursing problems and that traditional methods of charting should be discarded overnight. But we do solicit the thoughtful consideration of those involved—doctors, nurses, and hospital administrators.

The practice of extensive charting probably did no great harm a decade or so ago. There were plenty of nurses. The physician was not crowded with an office full of patients demanding of his time. Today, the nursing shortage being what it is, every effort should be made to utilize our nurses to the utmost and not take up their time with clerical work of no immediate value. There are definite savings in paper, filing space and film where microfilming is used, as well as in the energy of the nurse. These savings are substantial in the aggregate.

Has the new form been received with overwhelming enthusiasm? The answer would probably be in the negative. You see, a wonderful thing called "tradition" has been rudely awakened and left shivering in the cold, calculating eye of a cost-conscious hospital. Is it possible that "tradition" could also be spelled "i-n-e-r-t-i-a"?



FRONT ENTRANCE OF REDWOOD FALLS HOSPITAL, REDWOOD FALLS, MINN.

THE MODERN HOSPITAL OF THE MONTH

The bargain at Redwood Falls:

FULL FACILITIES IN A SMALL PACKAGE

EVERETT HOLES
Carl H. Buetow, Architect, St. Paul

THE city of Redwood Falls, Minn., in an effort to improve hospital standards for an area of approximately 17,000 persons, commissioned the architect to design a new hospital of 41 beds to replace an obsolete 20 bed unit. The proposed site was owned by the city and was located on the east side of town between two arterial highways. The site, wisely chosen because of the sloping terrain, afforded ample drainage and gave the designers an opportunity to utilize a ground floor for service facilities, thereby minimizing the long horizontal circulation problems evident in a one-story building.

The two-story building, financed with Hill-Burton assistance, allows separation of the service area located

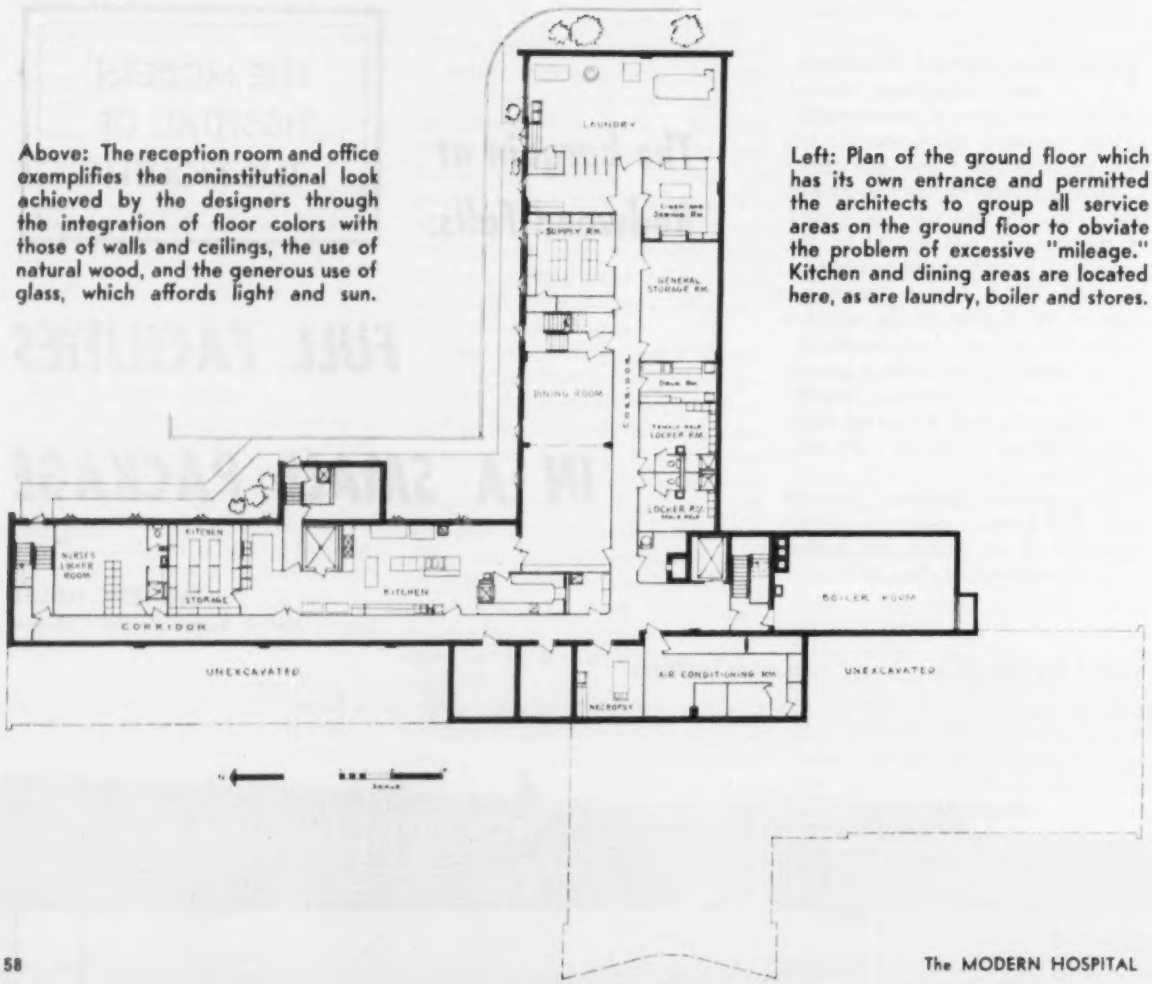
(*Continued on Page 60*)

WEST ELEVATION OF THE 41 BED TWO-STORY HOSPITAL.





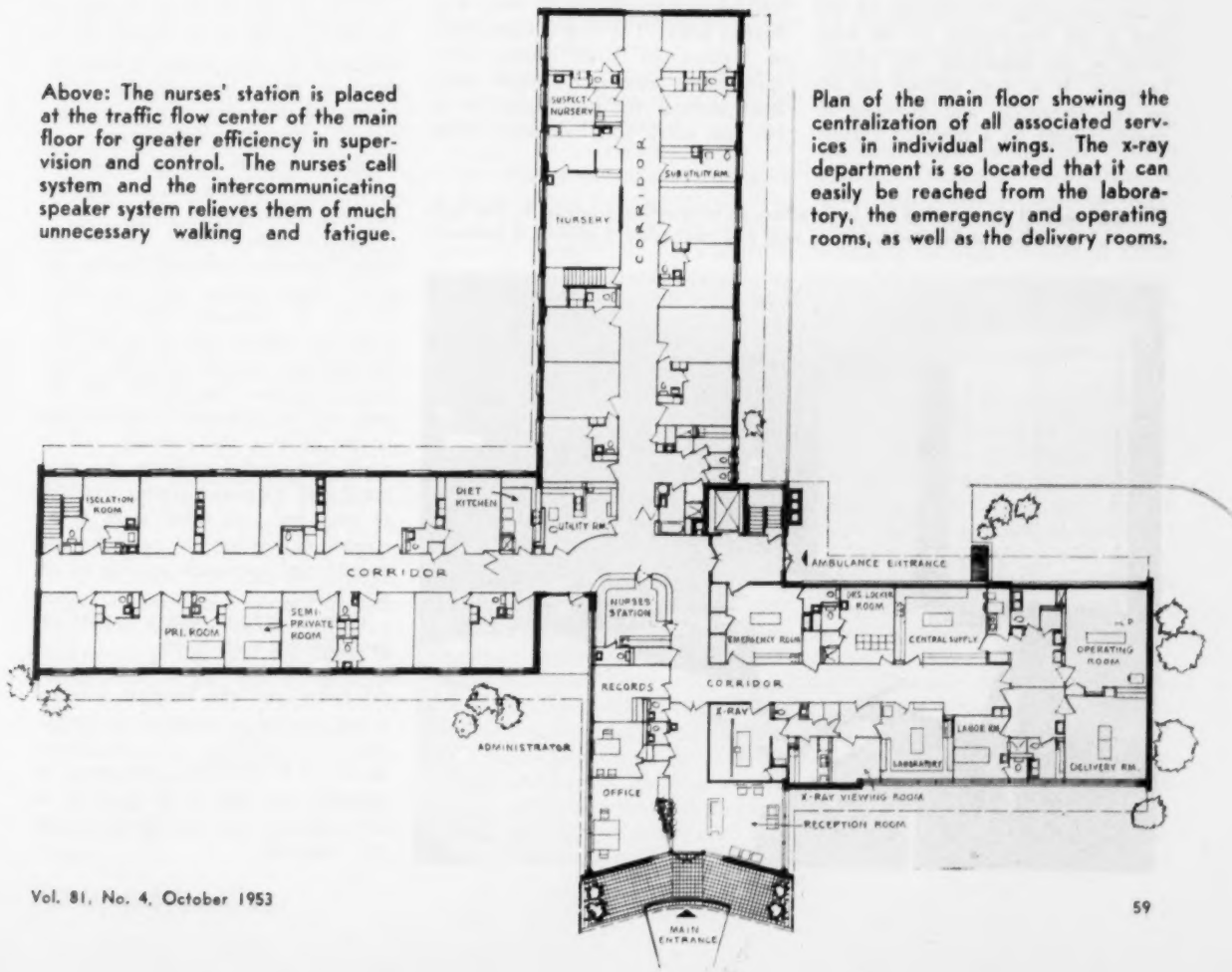
Above: The reception room and office exemplifies the noninstitutional look achieved by the designers through the integration of floor colors with those of walls and ceilings, the use of natural wood, and the generous use of glass, which affords light and sun.



Left: Plan of the ground floor which has its own entrance and permitted the architects to group all service areas on the ground floor to obviate the problem of excessive "mileage." Kitchen and dining areas are located here, as are laundry, boiler and stores.



Above: The nurses' station is placed at the traffic flow center of the main floor for greater efficiency in supervision and control. The nurses' call system and the intercommunicating speaker system relieves them of much unnecessary walking and fatigue.



Plan of the main floor showing the centralization of all associated services in individual wings. The x-ray department is so located that it can easily be reached from the laboratory, the emergency and operating rooms, as well as the delivery rooms.

COST DATA

Total project cost, including Group I, II, and III equipment	$537,446.00
Cost per bed	13,436.00
Cost per square foot	17.88*
Cost per cubic foot	1.55*
Cost of construction, including Group I equipment	436,628.00
Number of square feet	24,400
Square feet per bed	610
Number of cubic feet	281,695

*Includes construction costs plus fixed equipment only.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month

(*Continued From Page 57*)

on the ground floor from the nursing area located on the first floor with each floor having its own entrances off grade. The nursing area incorporated the centralization of all associated services in individual wings with the nurses' station placed at the traffic flow center for supervisory efficiency.

An interesting development of this plan is the relationship of the x-ray room to the laboratory and adjunct facilities. It is well adapted for use by one technician and provides accommodations for a traveling radiologist and for an outpatient x-ray and laboratory service.

The division of nursing care from service facilities eliminates noise and congestion common to those areas. Where noise factors are a problem, as in corridors, nursing and service room areas, ceiling surfaces are acoustically treated.

The building is constructed with load bearing masonry walls faced with Roman brick. The roof is constructed of lightweight steel trusses, clear spans being used and integral cantilever sections for sun shades on all but the north side. Concrete floors are finished with asphalt tile, terrazzo, cement or ceramic tile. All door frames are of hollow metal construction and are set in 2 inch solid plaster partitions. The doors are wood of flush panel design. Aluminum casement and double-hung windows are used throughout, and, because of the severe Minnesota climate, the windows are double thermal glass.

One of the outstanding features of the building is the absence of institutional characteristics. This has been achieved by the pleasing use of color; by the generous use of glass, which introduces daylight into almost every room; by the use of natural wood, and by the integration of floor colors with those of the walls and ceilings.

Mechanical consideration for effective heating and ventilating was accomplished by using a hot water boiler on a forced convector system with a steam boiler set up for sterilization and heating of the domestic water supply. The steam boiler, by means of a convertor, acts as a stand-by heating unit. Convector radiators are zone controlled and furnish heat upon thermostatic demand.

Fresh air, heated and humidified, is injected throughout the rooms and is evacuated by an exhaust system located in three inconspicuous penthouses on the roof. These are integral with the architecture and eliminate the roof type of exhausters, which are unsightly on an exposed flat roof surface.

Indirect light fixtures for the patients' bedrooms, recessed fixtures for most other rooms, and fluorescent fixtures in corridors, all with low brightness effect but with adequate foot-candles, provide pleasant working conditions. The nurses' call system and intercommunicating speaker system relieves the nursing staff of much unnecessary walking. An automatic dial telephone system, available to each bed and other areas as required, eliminates the need for the switchboard operator's services on inside calls.

Central oxygen supply outlets are provided for each room.

Splendid cooperation by the hospital board and the hospital administrator resulted in harmonious integration of building and equipment. Redwood Falls Hospital because of its completeness affords its patients all the technical facilities offered by large city hospitals.

The dark wall at the head of the beds offers an interesting contrast to the light color of the other walls, the furniture and gay draperies. Lighting is indirect.



As Doctor Sees Nurse—and the Same to You, Sir!

In this survey, both groups were frankly critical, and both groups had suggestions for improving teamwork, with the administrator playing the key rôle

DANIEL SCHECTER
New York City

THE last half century has witnessed a not so silent revolution in the relations between doctors and nurses in hospitals. From the physician's "handmaiden" of bygone days, the graduate nurse of 1953 has blossomed into a much more respected member of the professional health team. Her campaign for increases in salary and status continues, but the first battles have been won. While physicians have welcomed the professional growth of the nurse, they have become distressed by, among other things, her "lack of dedication" to her job, her allegedly failing interest in bedside care, her broaching on what traditionally have been considered doctors' prerogatives, and her aggressive drive toward still further recognition at what some doctors feel is their expense.

To find out what trouble spots exist in doctor-nurse relations and how they may be remedied, I interviewed in person and by mail more than 100 of the country's leading physicians, nurses and hospital administrators. They were selected because of their prominence or because of their reputations as being especially well informed about their positions and types of operation. Many interviewees requested anonymity—some because of the controversial nature of the topic and others because they did not "go through channels" to have their replies cleared. However, their candid responses to these questions may provide hints for future harmony:

1. Over what issues do misunderstandings between doctors and nurses arise?

2. Do most doctors agree on the extent of the services a graduate nurse can render?

3. Do most doctors understand nursing technics?

4. Do doctors explain to nurses the objectives they are seeking in a diagnosis?

5. Do doctors interrupt any nurses' procedures and cause them to be unable to complete them?

6. What can the administrator of a hospital do to improve relations between doctors and nurses?

Causes of misunderstandings between doctors and nurses are legion. Acknowledging the existence of friction, interviewees look to the administrator of a hospital to play a key rôle in its alleviation. They recognize that the psychological climate set by him influences all interpersonal relationships in the hospital. If the administrator knows his staff well, he often can make them aware of each other as individuals. He can avoid misunderstandings by explaining individual problems or differences.

For many years nurses have been fighting to better their economic and social position in the hospital. Now that some of their aims have been achieved, hospital directors say they no longer are so aggressive. Still, many physicians lament the passing of the "dedicated" nurse who was not so outspoken about written and detailed personnel policies, overtime pay and other mundane matters.

"Now nursing to many is merely another job to be worked at so many hours," said one administrator. He noted a "harshness and competitiveness" among nurses but remarked that they were just "reacting to all the forces of a damned complicated civilization." Nurses everywhere countered charges of being "mercenary" by pointing to their relatively low economic status. To the charge that they are less "dedicated" to bedside care, many nurses replied that the shortage of professional staffs in hospitals had led them to undertake new administrative duties, especially the supervision of nonprofessional nursing personnel.

Because of the nursing shortage, the burdens of those on duty have become arduous. Doctors in their desire to have their patients cared for sometimes have not realized the need for a nursing program balanced to ensure that the more seriously ill patient would get the most attention. Doctors tend to forget this because of the nature of the doctor-patient relationship.

More than 50 per cent of the nursing care administered in the United States is done by nonprofessional workers; and if replies to my queries are indicative, many physicians do not know which tasks are to be performed by graduate nurses, practical nurses, aides, ward secretaries, or hostesses. In some cases similar uniforms have caused confusion. Instances were reported in which doctors, mistaking nonprofessional nurses for professionals, had given orders and then chastised the recipients for failure to execute them properly. Likewise, in some hospitals physicians ignorant of the institutions' organization have complained to administrators about the refusal of nurses to perform tasks

NURSES SAID:

Doctors forget nurses are women

Nurses have new responsibilities

Doctors' attitude still "feudal"

Nurses are still underpaid

rightfully belonging within the realm of the dietitian or social service department.

Physicians are justifiably irritated and impatient at bungling nurses, and some nursing leaders candidly admit that there are many burglers. It has been charged that some students are admitted to schools of nursing who are poor material but are kept on because they are another pair of hands. Many graduate nurses reportedly are retained on the pay roll for the same reason. Several respondents commented on nurses' "lackadaisical attitude toward the adherence to prescribed medications and treatments with the increasing incidence of mistakes relative to drug administration."

Many doctors and administrators contended that nurses had become so interested in the details of medical care that they had lost some of their enthusiasm for routine bedside nursing. For example, Dr. John O. Boyd Jr., a member of the Commission on Hospitals of the American Academy of General Practice, said that in the area of Roanoke, Va., "it is quite common for a floor supervisor to be critical of the professional care rendered by the attending physician, and doctors do not feel that this is within the province of the nurse. As this interest in technical procedure has expressed itself, there has been definitely less interest in the technic of bedside care. Today many patients express themselves to the effect that if it were not for the assistance of nurse's aides, they would have been most uncomfortable during their hospital stay."

Dr. Boyd observed that nurses, perhaps reflecting certain elements of public opinion, had become "increasingly critical of the habits and behavior of the attending physicians." He said nurses possibly were encouraged in this attitude by "the desire in some schools to make of them supervisory personnel and/or attendants almost on a par with the intern resident staff. Doctors feel that the old adage 'A little knowledge is a dangerous thing' is particularly applicable to the current attitude of the nurse educators regarding the training of student nurses and their desire [nurses] to increase courses in medical diagnosis and treatment."

Dr. Martin Cherkasky, director of Montefiore Hospital in New York City, remarked that "since in most instances it is a characteristic of our culture that the higher the status the less physical work is required, the nurse, in her drive to improve her status and position, has found physical care of the patient less desirable and less satisfying."

Despite accusations by physicians, nurses stoutly insist that they do not want to be "pseudo-doctors." Nurses maintain that they are not seeking to take over doctors' work, but that some of what once fell to the doctor now has fallen to the equally busy, scarce and now highly trained graduate nurse. Just as the question arose some 50 years ago whether the nurse should carry a thermometer, or 25 years ago whether she should take blood pressures, the question most frequently raised by respondents in this survey was whether nurses practiced medicine by giving intravenous injections.

Dorothy Morgan, director of nursing at the University of Chicago Clinics, contended that "many doctors do not realize the full extent of the services which nurses who are graduates of the present-day good schools of nursing can give them. One of the reasons for this may be that it is possible that they may not know what is being taught in those schools. From current literature across the country it would appear that there is a great deal of criticism offered by doctors of present-day nursing education but one wonders how many of them thoroughly investigate the training programs to find out for themselves the aims and objectives of the nursing educators, the enormous problems involved in the education of nurses, and what is being accomplished frequently even in the face of extreme difficulty.

"On the other hand, there are those doctors—God bless them—who do take part in the education of nurses and therefore have a knowledge of the best which may be achieved in nursing. For the help and counsel of these men nursing is grateful. One thing remains certain, nursing must always coordinate closely with medicine and medicine with nursing if we are to attain the highest standards of patient care. Each has its part to play in the treatment of patients, a part which is *different* but which is *necessary* in the total care. Nursing education, the same as medical or any other kind of education, cannot remain stationary; it must meet the needs of the times. It must keep abreast of medical progress or it no longer meets the needs of the medical profession."

Physicians point with pride to their independence and their opposition to regimentation. In a hospital it often may become the unhappy lot of the nurse to police these "free lancers" and to make certain that rules are upheld. Mark Berke, director of Mount Zion Hospital in San Francisco, stressed, "The physician is by training an individualist who considers the hospital as a vehicle for the performance of functions that relate to him and his patients only. His concept of the hospital is that of an extension and elongation of his personal capacities. I believe this is as it should be, since the best medical care will be rendered on this individual basis. Nevertheless, emotionally if not intellectually, the physician wants the nurse and other personnel to be his own personal attendants, meeting first of all the needs of his patient. The nurse, on the other hand, is aware of her place in the organization and her responsi-

bilities to all patients, physicians and personnel."

Bitter accusations and sarcasms leveled during periods of tension often leave their mark on relations between doctors and nurses. A Pennsylvania director remarked that "the nurse often has little appreciation of the strain under which the physician works in case of high emergency. On high tension he issues orders, the nurse resents being ordered about, and conflict results at a time when a cool answer is needed. The nurse has not yet gained enough security in her new rôle quietly and calmly to take what she deems unjust criticism."

With their "newly won freedom" nurses have begun to act more as equals in social intercourse too. Many stay seated when doctors approach their stations. Doctors used to be the first off elevators, but frequently they no longer are. While the situation, of course, varies with individuals, nurses complain that many doctors pay inadequate attention to the social amenities.

One nurse replied sharply, "Many doctors forget nurses are women and like to be treated so." Others noted doctors' "lack of consideration and courtesy." Some nurses objected to doctors' calling them by their first names, although most welcomed it as part of the informal pattern of American society. A physician-administrator observed, "Most of the doctor-nurse problems fall into the realm of giving the doctor a chance to blow off steam he may not be able to blow off at his wife or office nurse." To illustrate his point, he told the story of the doctor who, after bringing a nurse to tears with a severe dressing-down, shouted at her, "Oh, oversensitive too!"

Competition between the male and the female is blamed for some doctor-nurse friction. "It arises," said one nurse, "from the misunderstandings which spring up in a situation where a man and a woman work together and where one or the other looks upon himself or herself as the superior of the two." Nurses are most definite in expressing their emancipation from what many felt to be a servant-master relationship with doctors. They feel freed from "the military regime," "feudalism," "military discipline," "a subservient attitude."

Foreign-trained and older physicians are reported much more critical of nurses than are younger physicians and seem to miss receiving what they consider "due respect." The nursing director of a prominent university hospital commented that women doctors are harder on nurses than are male physicians. Many respondents said that doctors who had worked closely with nurses in the armed services, where both were commissioned officers, had increased understanding and interest in nursing work.

DOCTORS SAID:

Nurses are no longer "dedicated"

Too many nursing mistakes

Nurses shouldn't criticize doctors

Strains of medicine not understood

Do most doctors agree on the extent of the services a nurse can render? Although most respondents stated that physicians should agree on the scope of nurses' services—particularly in their own hospital, where they should be conversant with the ability of the nursing department—the shortage of nurses and frequent changes in personnel often make this difficult. Confusion exists not only among doctors, but among nurses too, over how much nurses are permitted by law to do. The extent of nurses' services is likely to be measured by momentary need. Several administrators said no real attempt had been made to determine the extent of such services and, consequently, duties that were previously considered medical have been assigned to nurses.

"An educational program on a national level seems to be indicated," said Mr. Berke, "but this would require the representatives of organized medicine, nursing and hospitals to sit down and to agree on a general program covering the activities of the nurses. In addition, this might have to proceed collaterally with attempts to change laws in various states if necessary."

Do most doctors understand nursing technics? Not well enough, replied the majority of nurses and administrators interviewed. They said physicians with such understanding are more appreciative of the difficulties nurses encounter in fulfilling their orders. Nurses suggest that if doctors know more about how to carry out nursing technics—including orders for their own patients—they can anticipate better their patients' reaction to treatment. Furthermore, nurses note that because physicians frequently are not familiar with nursing technics orders are written that are difficult to carry out.

A leading psychiatric nurse said, "Many doctors merely know how to order certain treatments to be given and do not know the length of time it takes to give the treatment or the physical difficulties in giving it. I recall once talking to doctors and saying that they were ordering so many treatments for the patients that the nurse was unable to get through her day. I gave as an example the giving of a wet sheet pack and told of each step and the amount of time it took. One of the doctors said, 'You know, I never thought of that. I think I'm going to come in and have you teach me how to give a wet sheet pack.' *Treatments* ordered by doctors become *procedures,* often conceived and worked out by nurses, and the length of time in carrying out these procedures varies with the amount of equipment to be used, the actual number of physical movements to be made, and similar details."

Do doctors explain to nurses the objectives they are seeking in a diagnosis? Interviewees generally agreed that if more physicians informed nurses of their objectives, nurses' work would be more fruitful and enjoyable, and their notes would be more nearly complete. The danger in this, as viewed

WHAT ADMINISTRATORS CAN DO:

1. **Moderate nurse-doctor disputes**
2. **Interpret each group to the other**
3. **Prepare nurse-doctor bulletins**
4. **Orient new staff members properly**
5. **Promote group discussions**
6. **Encourage "socializing"**

by some, is of "standardizing human behavior" by ruling that all doctors should give explanations to all nurses, even when there is no apparent benefit to the patient or when the nurse is not capable of understanding.

Replies indicated a willingness by doctors to explain to interested nurses but a feeling that many nurses had no such interest. Some nurses expressed annoyance that doctors explained to patients the action of new drugs while neglecting to explain to nurses.

Mary C. Schabinger, superintendent of De Ette Harrison Detwiler Memorial Hospital in Wauseon, Ohio, urged doctors to explain their objectives to nurses. "The nurse is no different from any other worker," she emphasized. "She will put out extra effort more willingly if she understands the objective. She also is not at a loss when patients question her. Therefore, her work is made easier as well as more interesting and satisfying."

Another administrator noted that "the patient sees doctors and nurses as persons of authority. The family seeks information from both." When the doctor doesn't keep the nurse informed, the doctor and the nurse may be at cross purposes in talking with the family, he suggested.

In many instances the question of whether doctors explain their objectives to nurses revolves around who should make the first move. Should the doctor offer, or should the nurse ask? Such uncertainty seems to be a major reason why more explanations are not given.

Do doctors interrupt any nurses' procedures? The consensus was Yes, but further examination revealed that visits at irregular times usually were caused by physicians' busy schedules. The most frequently heard complaint was against doctors who appeared at mealtimes to make examinations or to change dressings. In their replies, nurses noted that many patients lose their appetite for food after such sessions, and that if they retained their appetite, the food had become cold and unappetizing.

A Pennsylvania administrator said, "It would be difficult for the hospital to change the mealtime habits of all its patients to please the doctor since mealtimes are pretty well standardized all over. The hospital is dedicated to patient care. The patient has enough adjustments to make because of his illness without changing the basic pattern of his existence. This is one instance in which interdepartmental relationships need to be amplified to clarify the issue and give somewhere."

To cut down on physicians' interruptions of nursing procedures, one administrator suggested that hospitals' time schedules be worked out in conjunction with those of others in the vicinity. For instance, a one-hour difference in starting time may allow doctors to make rounds in several institutions at regular times.

In this and other instances, it was pointed out that the hospital administrator can interpret the doctor to the nurse and the nurse to the doctor and, like the lubricant between a bearing and its journal, cut down friction.

"If the administrator feels that the nurse is a most important part of the hospital team, his doctors will soon come to accept that also," said a Kansas nursing director. An Illinois nurse suggested that "an administrator must be prepared to 'back' the nurses as well as the doctors within his institution if the nurses have plans or ideas that are going to promote patient care. Too often our nurses feel that they do not receive from their administrator a hearing equal to that the doctors receive." Another nurse indicated that doctor-nurse relations in her hospital suffered because the administrator was subservient to doctors upon whose patronage the hospital depended.

The administrator can help doctor-nurse relations get off on the right foot by establishing a good orientation program for new staff members. This is of special help to young house officers uncertain of their responsibilities. Interviewees pointed out that interns sometimes come from medical schools where they have not been taught the functions of nurses or team relationships. A successful orientation program tends to make them less reliant on nurses' advice, which this survey indicated they are somewhat reluctant to take.

A nurse in Maryland suggested that "hospital administrators could assume part of the responsibility for orienting doctors to the shortage of nursing personnel and how it concerns them. For example, it is a time-honored custom for nurses to assist doctors in many treatments and procedures. In certain ones, the nurse is useful; in others her rôle is hardly more than ornamental. There are too many other things that they could do and should be doing. And so the administration should make it clear to doctors that they are not to ask for a nurse's assistance when they don't need it."

The three groups generally agreed that if administrators could arrange for doctors and nurses to get together for discussion of mutual problems, preferably before they become grievances, some of the tension might be reduced. But despite the often-expressed need for face-to-face meetings, certain doctors who have looked down at nurses for many years have disdained a discussion among "equals." Despite advancements in nurses' training, it still is clear that many doctors do not consider—or consider reluctantly—nurses as professional people.

That the administrator act as a moderator in doctor-nurse disputes also was suggested. One physician said, "The administrator can maintain close liaison with the superintendent of nurses and interpret to her the criticisms which he receives from the medical staff relative to nursing care. Certain administrators, possessed of the gift, may tactfully insert themselves between the nursing superintendent and the chief of staff as moderator in questions which might produce misunderstandings by one or the other."

Other suggestions of what administrators might do to reduce doctor-nurse discord included:

1. Prepare a handbook for doctors on nursing personnel, including information about supply and better use of personnel, job classifications, and the like.

2. Issue a monthly bulletin to be sent to both groups on matters of common interest, such as the nursing shortage.

3. Appoint nursing representatives on medical board committees.

4. Include nurses in planning groups of units to be opened.

5. Have written rules for relations between doctors and nurses.

6. Encourage doctors and nurses to "socialize" at parties.

7. Make it possible for nurses to attend doctors' lectures and to be present at case conferences.

8. Urge doctors' moving their offices into hospitals to take an active interest in institutional problems, such as doctor-nurse relations.

9. Urge doctors to appear at nurses' institutes.

10. Ask doctors to help in solving problems of the nursing department.

Whatever conflicts have existed between doctors and nurses are aggravated today. The shortage of physicians and nursing personnel, the rapid development in diagnosis and treatment, and increased patient loads in hospitals have brought new burdens to overworked personnel in both groups. But despite these conditions, interviewees agreed that relations between doctors and nurses had improved.

Oliver G. Pratt, executive director of the Rhode Island Hospital, said, "More and more doctors are giving leadership to the team approach to patient care. Nurses are now able to carry out many procedures formerly considered safe only for the doctor to do."

Tracy B. Hare, administrative director of Variety Children's Hospital in Miami, Fla., stated that the doctor today is treating the nurse "as a colleague rather than a servant, especially those supervisory nurses with whom they come in contact. I think there are many signs of mutual cooperation which are encouraging."

Dr. Roger DeBusk, administrator of the Samuel Merritt Hospital in Oakland, Calif., wrote, "I believe the medical profession is giving the nursing profession credit for being an integral member of the team and an aid in the diagnosis and treatment of patients rather than as in the past considering the nurse as a 'laborer' of the hospital."

Dr. Morris Hinenburg, medical care consultant of the Federation of Jewish Philanthropies of New York, replied, "I've seen a close teamwork arrangement. We have recognized that you can't treat just heart disease, for example. You have to treat the whole patient. The team does this."

Nurses sense the improvement too. Agnes Gelinas, chairman of the nursing department at Skidmore College, remarked, "Doctors are showing a deeper and friendlier interest in the problems of nurses."

Machteld Huisman, director of nurses at Cedars of Lebanon Hospital in Los Angeles, said, "In this part of the world there is more freedom. On the whole the relationship is better because it is less paternalistic."

Dr. R. Louise McManus, chairman of the division of nursing education at Columbia University's Teachers College, told me that she saw "many more instances of cooperative planning than 10 years ago."

Ruth Sleeper, president of the National League for Nursing and nursing director of the Massachusetts General Hospital, and Dr. Dean A. Clark, the hospital's general director, agreed in a joint statement that doctor-nurse relations "have been improving. Doctors have sat down oftener to plan with nurses for the patient's care."

Esther Thompson, nursing associate of the Rochester Regional Hospital Council in New York, replied, "I believe there is evidence of a gradual improvement. There are unusual examples of effective team relationships."

If medical and hospital people do not foresee complete harmony between doctors and nurses in the near future, at least recent improvements give them cause for optimism. The very personnel shortage that has fostered so many problems apparently has forced doctors and nurses to concentrate more intensely on improving their labors together in the interest of better patient care.

ADMINISTRATIVE CAPSULES

WE RESPOND TO acuteness and urgency, but we also try to cure the patient of his illness. The first requires experience, the second study.

GREATER LONGEVITY means that we not only have a longer time in which to live but also a longer time in which to die.

THE GERIATRICIAN is not a specialist. He is a very desirable general practitioner with a special interest in the elderly. Beware of the physician who announces that he is a specialist in chronic diseases!

THE DOMINANCE OF URGENCY in calling forth a prompt medical reaction has dulled our planning faculties in the presence of the patient suffering from prolonged illness.

WANTED: a redefinition of conscience in relation to chronicity.

NOWHERE IN THE GOOD BOOK are we commanded to succor the acute and the urgent. All of the emphasis is on the chronic, the aged, the orphan, the widow, the maimed, the halt and the blind. To some situations we respond instinctively; to others only under pressure.—E. M. BLUESTONE, M.D., *consultant, Montefiore Hospital, New York City.*



DR. RANDOLPH LEE CLARK Jr.

THE CLARK STORY

Opening of the University of Texas M.D. Anderson Hospital for Cancer Research in Houston, will focus spotlight on its director, Randolph Lee Clark Jr.

SUE BARNETT
Houston, Tex.

THE hospital-medical field spotlight this fall swings deep into the heart of Texas where a beautiful new institution and its director are the center of attraction in the Texas Medical Center.

Randolph Lee Clark Jr., B.S., M.D., M.Sc. (Surgery), Lt. Col., will preside over the ceremonies opening America's most modern cancer station, the University of Texas M. D. Anderson Hospital for Cancer Research in Houston. Dr. Clark is director and surgeon-in-chief.

Reciting his title, however much responsibility and success are obvious therein, falls short of explaining why Lee Clark shares the spotlight with this new $8,000,000 institution. When he took over the duties of hospital director in 1946 there was available for the building program the sum of $1,750,000. Dr. Clark's indefatigable efforts finally pushed the building fund above the $8,000,000 mark when construction was well under way.

Dr. Clark's activities at the end of his first seven years with Anderson now are swinging toward the medical director's duties, with more and more administrative work left in the hands of the administrative staff. In this area Dr. Clark has surrounded himself with unusually capable and generally youthful nonmedical assistants, as well as bringing to the hospital staff outstanding men and women in the scientific field.

The administrative setup at Anderson follows the university teaching hospital organizational pattern, with full-time persons in all key jobs.

Anderson Hospital is but one member of the state cancer team or the nationwide cancer team. Most malignancies are and always will be cared for in the general hospitals, just as the great majority of cancer cases will be found by the general practitioners.

"However, because there was need," Dr. Clark says, "for a central agency to acquire and disseminate special cancer knowledge and to assist in the continuing education of the physicians who take care of the cancer cases, the University of Texas assumed this responsibility, with enormous aid from outside sources."

Such an institution as Anderson is a stimulus to the necessary cancer-consciousness of all physicians, who can turn to it for special training, statistics, or to see groups of cases of certain types. It fills a state need as a major experimental station, and in turn it benefits from the invaluable material sent to it as a university research hospital by physicians all over the state.

This team idea that Dr. Clark emphasizes has been a lifelong influence with the 47 year old surgeon. He and his wife, Dr. Bert Davis, have shared their professional as well as their private lives. They went through medical school together, took residency training together in Paris, and took further study together at Mayos.

Dr. Bert Davis now is a practicing anesthesiologist in the Texas Medical Center, and no doubt this fact has a bearing on the unusually thorough anesthesia program worked out for the architects of the M. D. Anderson Hospital. A specially designed two-way storage wall is loaded with gases piped to the operating suites and equipped on the operating room side with control panels to which the anesthetist may attach a thin hose. Sterile supplies are placed in stacks of drawer trays in another two-way storage wall of the operating rooms.

Another feature of the operating room setup is the special surgery room so designed that TV cameras can be suspended from two different angles. Television will be in color and op-

erations televised will be watched in comfortable conference rooms with two-way communication between the surgeon team and physician and student viewers.

The planning of this huge plant was unusually complex because of the multipurposes prescribed by the law that created the institution, that is, that it "shall be devoted to the diagnosis, teaching, study, prevention and treatment of neoplastic and allied diseases."

As an example of these complexities was the matter of providing the locations for the latest radiation equipment and the equally important safeguards to prevent radiation or even contaminated air from escaping the radiotherapy zone. These include walls of extra-dense concrete that are 6½ feet thick.

MAXIMUM NURSING EFFICIENCY

Other original features of the hospital were planned for the patient areas to give the nurses maximum efficiency in the 10 nursing units. The four-bed wards are nearest the nursing stations so the fewest steps are necessary in caring for the most patients. The two-bed and single-bed rooms are at the ends of the halls as many patients in these rooms will be able to afford private nurses. Between the two-bed and four-bed wards are sub-utility rooms, including bathroom facilities. Each patient room or ward has running ice water; there are oxygen and suction pipes in all surgical wards, surgical nursing units, and treatment rooms.

By each bed is a two-way radio connected to the nurses' station. Tube stations connect the nurses with central supply, pharmacy, record room, admitting office, business office and mail room.

The proportion of seriously ill patients in a cancer hospital is almost twice that of the average hospital, with more than 60 per cent of the patients being surgical cases. This requires more hours of nursing care per patient. Every effort has been made by Dr. Clark, his staff, and the architects to find means of freeing the nurses for as much bedside care as possible.

In addition to the strictly hospital type of problems that had to be solved for the new Anderson plant, consideration had to be given to the educational field, so important in Anderson's over-all contribution to medicine in the Southwest. For example, it is the only hospital in the region with a physics department, and has complete equipment for supervolt therapy. This includes the 24,000,000 volt betatron and the 2,000,000 volt cobalt 60 irradiator.

There are six full-time physicists on the staff, teaching, doing research and assisting in therapy, in addition to constructing new machines for their work. With fundamental research in physics becoming increasingly important in the cancer field, Dr. Clark has provided Anderson with the workmen and the tools in this highly scientific field.

When Dr. Clark joined the University of Texas institution, it was only two years old and its plant was a rambling two-story mansion to which had been attached a temporary frame building to serve as the outpatient clinic. This modest beginning for Anderson Hospital was made possible by gifts and other assistance from the original godfather of the Texas Medical Center, the M. D. Anderson Foundation. This foundation also has contributed more than one-third of the funds for the new hospital.

Coming out of the service as a lieutenant-colonel, Dr. Clark's wartime record includes these steps: into the air force in 1942 as chief of surgical services at the Regional Air Force Hospital in Goldsboro, N.C.; to aero medical surgeon general, and then to Randolph Field as chief of the surgical department of the School of Aviation Medicine, where he continued the research work that had been an important part of all his air force assignments. Before leaving the service in 1946 he wrote the surgical history of the army air force for the surgeon general, and since 1948 he has served as national consultant in surgery to the surgeon general of the U.S. Air Force.

In 1940, Dr. Clark and his wife, Dr. Bert Davis, had completed special training at Mayo Clinic and moved to Jackson, Miss., to become members of a five-physician team known as Shands Clinic. Part of the attraction in this setup was the plan of these doctors and a group of Mississippi leaders to establish a four-year medical college to replace the old two-year state school. The war interrupted these plans.

The reasons for Dr. Clark, the surgeon, to want and take the post of administrator of the hospital instead of continuing in the private practice are headed by that typical Texas point of view: "No Texan is ever satisfied until he returns to Texas. Also, there was the chance in Houston to build an institution comparable to any anywhere," Dr. Clark explains. "Surgery and cancer go together and in this plan was the opportunity to do surgery and research together, to become part of a university program and at the same time to become part of the big over-all project of the Texas Medical Center. Like many other physicians, I realized that Texas could use a major development in medicine and I liked the idea of being a part of that development."

Dr. Clark is widely known as head of the successful Medical Arts Publishing Foundation which he started in partnership with R. W. Cumley, former Chicago editor. They first launched the *Cancer Bulletin,* which has 55,000 subscribers among U.S. doctors.

ISSUE PSYCHIATRIC BULLETIN

The second publishing venture of the Clark-Cumley team was the *Psychiatric Bulletin,* started at the request of psychiatrists and now going to 37,000 physicians. The *Heart Bulletin,* with 70,000 subscribers, was requested by the American Heart Association last year. The three journals are self-supporting, are distributed in 40 states, and have exchange arrangements with 45 foreign journals.

The newest accomplishment of the publishing foundation is "The Book of Health," a medical encyclopedia for the layman. This handsome volume of knowledge pertaining to health and disease was scheduled for publication September 30.

In discussing the administrator-physician relationship, Dr. Clark reverts to his lifelong belief in teamwork. The two are a partnership, he says, and this is more than ever an important factor in modern medicine. The complexity of today's medical task makes both equally necessary, the administrator to provide the ideal conditions in which the physician can do his finest work.

"It is important," Dr. Clark maintains, "that there never be any question of employe-employer relationship. The physician should stick to the handling of the care of the patient and not get into management of the hospital. They have a mutual area and zone of operation, and the partnership is important to the success of each."

Basic Steps in Planning

THE NURSES' RESIDENCE

and Educational Facility

1. Programming Physical Facilities

LOUISE O. WAAGEN
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SOUND planning for any building starts far in advance of the preparation of blueprints. By the time architectural drawings have materialized months have been spent defining and agreeing upon need for the structure, selection and purchase of site, soil evaluation, finance, relationship of individuals and groups in program planning, responsibility, and virtually scores of other essentials requiring special skills, knowledge and procedures.

Planning functional facilities for educational or residence units requires the thinking and recommendations of many competencies. There are technical requirements for lighting, ventilation, acoustics, heating, decorating, plumbing, communications, power, construction. In addition there are other basic functional needs for space and arrangement affected by and stemming from trends, technics, philosophies and practices associated with the specifics of conducting any given nurse education program.

Although all of these are essential, this guide does not purport to discuss technicalities in the fields of engineering or architecture. Rather, it is concerned with describing tools and criteria useful in programming for those physical facility needs that are affected by and dependent upon variations in size, practices and purposes.

The characteristics of any two schools are not identical; neither are their needs for physical facilities. What is functional, convenient, economical for one may be entirely unsuited for another. However, certain elements are fundamental and applicable to every situation.

Beginning a series on educational and residence units for student nurses.

BASIC FACTORS

Four factors are basic to achieving physical facilities: (1) competent people, (2) sufficient money, (3) coordination, and (4) careful programming.

The first factor, competent people, refers to the building or project authority and advisers. The building authority is the executive-administrative body for the building project. Its immediate duties are to establish the need for construction, to procure and administer the funds required, to define immediate and long-term working relationships and resources, to appoint and direct advisers and other participants during the planning stages.

This project authority is usually limited to a few key persons. Representation in the group is largely determined by the (existing or projected) organization and administrative control of the school concerned. Examples of members (or their alternates) are:

1. The administrative authority or head of the governing establishment, such as the dean of nursing, college dean, hospital administrator, educational director.
2. The fiscal officer for the governing establishment, such as the business manager, controller, treasurer, chief accountant.
3. The nurse education authority for the nursing school, such as the nurse director, educational director.

In addition to the executive group, other competencies are required. Many interrelated services and activities are involved in the operation of an educational or residence unit. They may or may not be directly a part of the edu-



Planning a nurses' residence begins long before the architect is ready to submit his blueprints.



Student nurses' bedroom. Since no two residences are alike, each one must be adapted to the needs and circumstances.

cational system. They may be supportive to its maintenance and operation and to student welfare in general. In order to organize for unified and complete coverage of all needs, a planning committee is necessary. Whereas the executive group has limited representation, the planning committee has wide representation. Membership on this committee may include selections from nursing school; engineering, housekeeping and dietary departments; equipment and supply specialists; residence management; nursing service; fire department; laundry; student body; community or civic groups; nursing school accrediting body, and dean of women's office.

It must be remembered that this representation is for competencies concerned specifically with the project's needs and is not for the purpose of representing groups or categories of interests per se. The committee should not become so large that action and decisions are hindered, since its function is to provide the project authority with a workable building program.

The appointment of working committees (or subcommittees) is often advisable for working out details of the building program. There may be such a committee for educational needs, residence needs, equipment and supply needs, dietary needs, or any of the major considerations pertinent to the project being developed. In some instances, especially where no facility or staff has been previously established, respective problem areas may be analyzed and developed by a single individual or consultant rather than by a committee.

These working committees, or consultants, are the key to functional planning, since it is their responsibility to furnish the details upon which architectural plans will be based. Their contribution is by careful programming, the methods for which comprise the major portion of this manuscript. It is most likely that nurse participation will be through this channel.

The second major factor in attaining functional physical facilities is sufficient funds to meet essential needs. The responsibility for procurement of such funds rests with the project authority. Methods of financing do not come within the purview of this discussion. However, everyone who works with a planning group should have an appreciation of costs and a related sensitivity to the need for most economical use of funds.

Present experience indicates that the cost of constructing combined educational and residence facilities is approximately $18 per square foot. This figure can serve only as a very general guide, however, because of constantly changing prices, cost differentials from one geographic area to another, and the intricate differences and characteristics of individual buildings and their equipment.

For estimating total area in a general way, it can be said that a unit combining teaching and recreation areas, but having no general dining room or kitchen area, requires a minimum of 300 square feet of floor space per resident.

Each individual must plan for economy of space, equipment and arrangement so that the amount of money available will be used to best advantage. On the other hand, aiming for economy of initial construction cost alone is not necessarily good economy. Careful and judicious thought must be given to long-term effects upon economy and efficiency in operation. The building is constructed only once, but operational costs are continuing costs as long as the structure is in use.

The third basic factor is coordination. No single individual can know details of every need for a facility. Special knowledge of problems and requirements is essential.. These requirements, and the recommendations toward the building plan, must be coordinated for a smoothly functioning building, one having unity and balance. Each individual on the planning team must, therefore, recognize the fact that his contribution, important as it may be, is truly effective only when coordinated with the total skills of the entire group and when it is in harmony with the service and safety requirements of the whole building.

Programming, the fourth basic factor, is of greatest importance in attaining functional facilities. It constitutes the system and methodology that provide the information essential to the architect's plan. Programming is the technic or method for presenting to the building authority the statement of what is needed in the facility and the rationale supporting these needs. Programming for educational and residence needs includes several technical requirements in addition to those for teaching, such as sanitation, environmental factors, engineering, maintenance, health and welfare. Herein lies the key to analyzing specific need and arriving at answers applicable to individual problems and situations.

STEPS IN PROGRAMMING

There are five steps in programming: (1) collection of information and criteria about the school and residence; (2) area and room designation for the proposed building; (3) preparation of written recommendations; (4) administrative acceptance of the recommendations, and (5) follow-through.

Step 1—Collection of information and criteria about the school and residence. Advice and details for a functional physical facility must be based upon the practical operating characteristcs of the school and residence. Therefore it is most important that nurses who advise on education and

Physical Facility Needs for Office of the Educational Director*

Purpose, Activities of Area; Number People to Accommodate; Load; Frequency of Use.	*Special Features; Inherent Hazards*	*Equipment, Supply Affecting Area*	*Interdependence With Other Areas*	*Number Units Needed, by Location*
For administration of school, planning and management.	Private office mandatory, ensuring privacy for conferences and concerted work.	Executive type office, furnishings and supply.	Accessible to faculty and student body.	One office, preferably in block of office facilities, on main (entrance) level of building.
For exclusive use of director; cannot be shared with other personnel.	Must provide security for confidential records.	Files (size, number).	Secretarial office; waiting room adjacent.	
Will need to accommodate 3 or 4 additional persons during periodic conferences and interviews.	Private cloak room.	Bookshelves or cases (capacity).	Ready communications with other offices, class areas, auditorium.	
	No physical hazards.	Conference table (size).		

*Details are for illustration only and are not necessarily recommended criteria.

residence needs* know something of the particular situation they intend to help.

Advice may be sought for a school that the consultant does not know, for the establishment of a new school, or for replacement or remodeling of the school in which she is employed. No matter which situation is posed, advice is of limited and questionable value if it reflects only offhand, individual opinion and is not based upon pertinent, factual data and needs. This refers to data which identify type and size of school, methods of teaching, and administrative policies. The following examples suggest the scope of data pertinent to the project.

One of the most important facts to establish is the general nature of the school—the type of program to be offered (basic, advanced, collegiate, hospital, professional, practical, affiliating); length of program (in years or months); type and number of students (women, men, graduate, undergraduate, size of classes and student body); number of faculty members (full-time, part-time); classes to be given (number taught, where, for how many students); personnel to be accommodated (faculty, administrative, counseling, secretarial, maintenance). These will give leads to the desired size of facility as well as to other needs inherent in characteristics of the various programs.

Another consideration is the educational methods to be used by the school. Will teaching be by lecture, demonstration, laboratory, seminar or other means? Still another: How will supplies be furnished and from where? Each answer will be an indication for certain types of room delineation.

Establishing the methods to be employed leads to the consideration of another question: In general, what type of equipment will be required? Preparation of such lists in detail is a major undertaking and an additional part of planning. Consideration of equipment at this early stage of planning gives a preliminary picture of equipment that will affect size and arrangement of rooms. For example, what large pieces of equipment will be needed, what storage problems do they present?

What are the administrative policies that will affect decisions? Will other existing educational facilities in the community be used by this school (for sciences, basic academic subjects, clinical subjects)? How often will students be admitted? Will student occupancy of the residence be obligatory?

It is quite possible that the nurse will be expected not only to gather all this information but also to make recommendations and decisions as to what should constitute the educational program, methods and policies, as well.

The only reason for a physical facility is to provide functional media through which to render a service in a given way. Thorough acquaintance with the proposed services and programs of the school and with the ways in which they will be provided must antecede any attempt to formulate recommendations for facilities, if the buildings are to serve their real purpose.

Step 2—Area and room designation for the proposed building. This entails deciding what areas and rooms are needed in the light of requirements pointed up by the basic information about the school. In the actual work of planning for a facility it may be difficult clearly to separate Step 1 from Step 2. There is dovetailing, and rightly so, because informational data tend to lead, directly or indirectly, to translation into facility needs.

This is a crucial step demanding concise details based upon specific purpose. It is the major step that makes programming the answer to individual problems. Whether educational and residence units are combined or separate and how elaborate or how simple the buildings will be must always remain a matter of individual decision. Functional aspects should never be sacrificed for expediency in programming. Nor should one lose sight of the costs involved, both immediate and long-term.

How does one start?

Visits to existing educational and residence units and interviews with those who have recently had experience with a building program are always helpful. Shared experiences can be interpreted in terms of practical operation. Hospital and architectural literature is of much value. The fact nevertheless remains that no existing plan, however fine, will answer all needs elsewhere.

In starting to delineate areas it is helpful to prepare a broad classification of potential needs which can be expanded for a working outline and from which tentative selections can be made. For example, the following outlines

(*Continued on Page* 140)

*Nurse, consultant, nurse committee, and subcommittees are used interchangeably.



Administrator William J. Donnelly of Greenwich, Conn. left, included the convention in his family's 9000 mile vacation and sightseeing tour. Shown here with a friend (see next page) the Donnelly family—Bill Sr., Bill Jr., Nancy and Mrs. Donnelly—walk toward the auditorium.

A. H. A. Convention Report

SAN FRANCISCO.—Larded abundantly as it was with wives, children guests, and student nurses from near-by hospitals, registration at the American Hospital Association's 55th annual convention here last month nevertheless reached an impressive 10,300—far beyond the most optimistic estimates and enough to pack the aisles of the exhibition hall, making the exhibitors happy, and the room where the general sessions were held, making some of the delegates uncomfortable.

Many administrators brought their families along (see picture) and made the convention part of extended tours which took them all the way from Banff to the Mexican border. San Francisco's sightseeing buses were loaded with hospital people who ex-

(*Continued on Page* 148)



Meet Miss Modern Hospital of 1953, Ada Belle McCleery. Lured from 12 years of retirement, Miss McCleery makes her bow as our photographer's model.



1. Irresistibly, Miss McCleery is drawn to the scene of her early prime, for it was in San Francisco in 1928 that she was elected second vice president of the A.H.A. Here she is registering, with Robert E. Neff, administrator, Methodist Hospital, Indianapolis.



2. Among the first to greet the First Lady is a recent retiree, Joseph G. Norby of Milwaukee. They were accomplished brow knitters as A.H.A. trustees and as proponents of and pioneers in the A.C.H.A.



3. At every turn, the former superintendent of Evanston Hospital, Evanston, Ill., gets her small firm hand pumped by some Prince of Hand Pumping, such as Dr. R. C. Buerki of Henry Ford Hospital, Detroit. Between the two distinguished old friends stands a noteworthy new figure, Dr. James M. Mackintosh of London, who at the annual banquet was made an honorary member of the American Hospital Association.

4. Herself an honorary fellow of the A.C.H.A. in 1947, Miss McCleery is saluted by the 1953 honoraries: Karl B. Meister of the Methodist Board of Hospitals and Homes, Raymond P. Sloan, president of The Modern Hospital Company, Maj. Gen. George E. Armstrong, surgeon general of the army; Vice Adm. Joel T. Boone (V.A.); R. Adm. Lamont Pugh, surgeon general of the navy; Maj. Gen. Harry G. Armstrong, surgeon general of the air force; Dr. Leonard A. Scheele, surgeon general of the United States Public Health Service.





5. Msgr. Donald A. McGowan of the National Catholic Welfare Council is proud as Punch to team up for a picture with our Judy at Fairmont Hotel.



6. Miss Ada Belle is the belle of the banquet as she enters on the arm of "Dr. Bones of Barnes." Dr. Bradley was named the president-elect of the A.H.A.



7. "Dr. MacEachern, I presume," exclaims Miss McCleery as she slips into a love seat beside the best known figure in modern American hospital history.



8. At her 25th official opening of an A.H.A. convention, Miss McCleery is flanked by William B. Smith of Hospital Industries Association, Maurice Norby, deputy executive director of headquarters staff, and Dr. Edwin L. Crosby, A.H.A. president.



9. At House of Delegates session, Dorothy Pellenz of Crouse-Irving Hospital, Syracuse, N. Y., and Charles M. Royale, executive secretary of the Hospital Association of New York, have a refreshing conversation with Miss McCleery on nursing school accreditation.

10. In the architectural exhibit, W. J. Dutel, Edward Tulis and Frank Hamilton of the V. A. Hospital in Houston, Tex., huddle with Miss McCleery and Ellis J. Berhman of Beth Israel Hospital, Newark, N.J., around an attractive Hill-Burton model.



11. Miss McCleery has a special feeling for James G. Carr Jr., administrator at Casper, Wyo., whose dad was Evanston medical chief.





12. A cluster of Sister administrators appear in Miss McCleery's orbit, namely Sr. Mary Stanilaus of St. Mary's, San Francisco; Sr. M. Altissma of Bethania Hospital, Wichita Falls, Tex.; Sr. M. Amata of St. Mary of Nazareth Hospital, Chicago, and, almost lost in shadows, Sr. M. Philippa, head of St. Mary's Hospital, San Francisco.



13. A corridor encounter with Oliver G. Pratt of Rhode Island Hospital, Providence, is regarded as providential by the party of the second part as well as by Miss McCleery, California resident.

14. In the entrance tent three comely maids from the Information Center converge to set Miss McCleery straight on all the possibilities for a convention returnee. They are Alice Johnson of the Association of Western Hospitals; Amy Harris, A.H.A. staff assistant, and Florence Purgett, hard working convention coordinator. A plump errand boy could not squeeze himself into range of the camera.



15. In exhibit territory, Miss McCleery stops to chat with Roger Wilde, H.I.A. president, and three nurse anesthetists from Michigan: Dorothy L. Case, Henry Ford Hospital, Detroit; Mary S. Martin, Ann Arbor, and Bridget Fleming, St. Mary's, Saginaw.



16. Once in two years is often enough for a national convention, contends Miss McCleery. Lawrence Payne, head of Medical Center Hospital, Tyler, Tex., laughs at this one, for New President Ritz Heerman (shown with Mrs. Heerman) needs a '54 convention to conduct.





17. Auxiliaries Chairman Mrs. Philander S. Bradford meets Miss McCleery. Mrs. Jac Ochiltree (right) powers the Delnor auxiliary at St. Charles, Ill., where Miss McCleery has been a hospital trustee.



18. They worked in unison in Illinois, so they drift together in California. Leslie D. Reid of Chicago's Presbyterian, Miss McCleery, and Stuart Hummel, now of Columbia, the gem of Milwaukee.



19. Cornelia Knowles, director of McMillan Hospital, St. Louis, recalls Miss McCleery as a favorite speaker at her first institute.



20. As "hep" on Hill-Burton hospitals as anyone, present company excepted, Miss McCleery's present company is Dr. A. J. Cronin, H-B head.

21. In this Camel Caravan are: Sam Z. Heeter, Children's Hospital, Columbus, Ohio; Harold Prather, East Tennessee Baptist Hospital, Knoxville; the strictly nonsmoking Miss McCleery, and Thomas Worobec of Shawnee, Okla.



22. On farewell shopping spree at V. C. Morris', designed by Frank Lloyd Wright, are Miss McCleery, Veronica Miller, Chicago, Jewel Thrasher, Dothan, Ala. and Katherine White-Spunner, Mobile.



PROTOTYPE STUDY: THE 100 BED HOSPITAL

All the facts about the 100 bed hospital as it exists today—comprising a useful tool for self-evaluation and an adaptive guide to administrative planning

LOUIS BLOCK, Dr.P.H.
Program Coordinator
Division of Medical and Hospital Resources, Public Health Service

THIS is the second in a series of prototype developments. The first of the series, "The 50 Bed Hospital," appeared in the June 1953 issue of The MODERN HOSPITAL. At that time the reasons behind the development of this kind of information were provided in some detail. It was emphasized that there was a need for making the tremendous store of hospital information available for general use; that certain of the data were arrived at through applying the proportionate variations from local averages in the areas where studies had been made to national averages; that a "prototype" is generally defined as a pattern that describes "what is" rather than "what should be"; that emphasis on the typical or average is beset with many dangers if not properly applied, and that it can be a useful tool for self-evaluation and as a general guide to administrative action when adapted to one's particular needs.

The following prototype is the second example of applying these technics and facts to a 100 bed nonprofit general hospital.

In this prototype of hospital operation for the 100 bed nonprofit general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.

BED DISTRIBUTION

Major. In more than half of these hospitals, medical, surgical, obstetrical and pediatric patients have beds specifically set aside for their use. For this reason they are considered as major services to such a hospital type and size group. Medical and surgical services combined account for approximately 66 per cent of all beds, obstetrics for 21 per cent, and pediatrics for 13 per cent. This means that the average 100 bed general hospital has 66 medical and surgical beds, 21 obstetrical beds, and 13 pediatric beds. The aforementioned bed distribution will be affected by assignments to additional services discussed hereafter. These hospital beds are segregated by type of accommodation as follows: 8 beds in private rooms; 38 beds in semiprivate rooms, and 54 beds in wards.

Additional. In addition to the four basic groupings of patients found in more than half of these hospitals, the 100 bed general hospital may make specific bed assignments for other patient groups. Because they occur in less than half of these hospitals they are considered as additional services. Table 1 indicates these additional services, frequency of their occurrence, and average number of beds assigned them.

Bassinet Distribution. The average number of bassinets for newborn is almost the same as for obstetrical beds, 20.

Almost 9 out of every 10 of these hospitals have infant incubators. They average 3 such units per hospital.

Only 1 in 3 has special nurseries for premature infants.

Closed Beds. One hospital in 11 reported beds closed for all reasons. They averaged 17 closed beds per hospital.

One hospital in 25 had beds closed for lack of personnel. They averaged 17 beds per hospital.

One hospital in 20 had beds closed for reasons other than personnel. They averaged 18 beds per hospital.

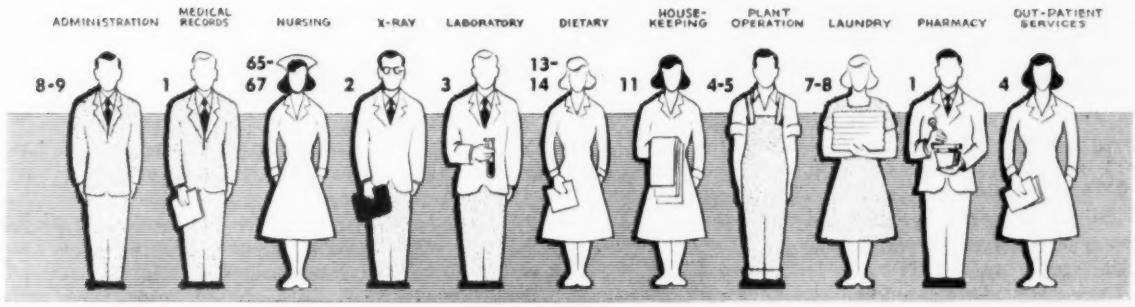
UTILIZATION

The kind, type and number of pa-

Table 1—Frequency of Additional Services

Patient Group	Frequency of Occurrence	Average Number of Beds Assigned
Isolation or contagious	1 in 6 hospitals	5-6
Chronic	1 in 20 hospitals	14-15
Nervous and mental	1 in 25 hospitals	11
Tuberculosis	1 in 100 hospitals	12

Average Number of Paid Personnel



tients admitted to the 100 bed general hospital are as follows:

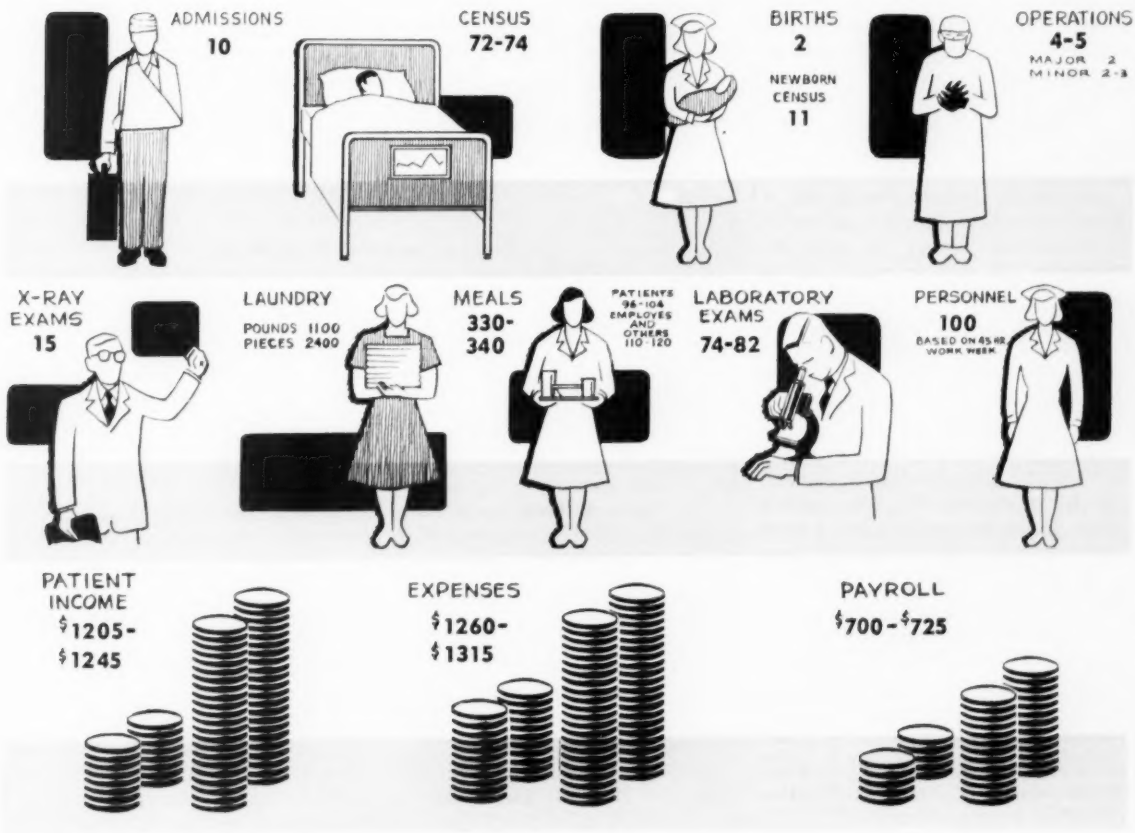
Admissions. An average of 3600 to 3700 patients is admitted during the year, averaging 36 to 37 admissions per bed per year.

Births. There are approximately 750 live births during the year. Of this number 45 to 50 will be premature. There will be an average of 8 sets of twins during the year, and 1 set of triplets can be expected every 18 months. There will be about 9 stillbirths during the year.

Deaths. There are approximately 125 deaths during the year.

The gross death rate (total deaths divided by total discharges) is around 3.3 per cent. This means that a little more than 3 out of every 100 patients discharged die in the hospital.

An Average Day's Activities



In this prototype of hospital operation for the 100 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.

There will be approximately 8 premature fatalities during the year.

Autopsies. An average of 25 to 30 autopsies is performed during the year.

This shows an autopsy rate of 20 to 24 per cent (autopsies divided by total deaths).

Patient Days of Care. The hospital provides around 26,000 to 27,000 days of care during the year.

Newborn Infant Days of Care. In addition, approximately 4000 days of care are provided for newborn infants during the year.

Average Daily Census. An average of 72 to 74 patients is cared for in the hospital daily.

An average of 11 newborn infants is cared for daily.

Percentage of Occupancy. The average annual percentage of occupancy approximates 72, varying from 55 to 60 per cent in private accommodations to 75 to 80 per cent in semiprivate and 70 to 75 per cent in ward accommodations.

Newborn occupancy approximates 55 per cent.

Average Length of Patient Stay. Length of patient stay averages 7 days.

This varies by type of accommodation as follows:

Private	7 days
Semiprivate	6-7 days
Ward	9 days

Semiprivate patients usually stay a shorter time than do either private or ward patients. Among the usual explanations for such an occurrence is that the pressure of finances requires the semiprivate patient to get back to gainful employment as soon as possible. Private patients may be in a better position to afford a slightly longer convalescence in the hospital. Ward patients, on the other hand, may have other factors dictating or affecting the length of time they stay. Among these factors are usually those of more advanced cases of illness and home conditions not conducive to convalescence.

Length of stay for all patients varies by diagnosis as follows:

Medical	11-12 days
Surgical	7- 8 days
Obstetrics	4- 5 days
Pediatrics	6- 7 days
Gynecology	5- 6 days
Genito-urinary	9-10 days
Orthopedics	10-11 days
Ear, nose and throat	1- 2 days
Ophthalmology	7 days
Other	5- 6 days

Almost three-fourths of all patients admitted are discharged within one week. The per cent of patients discharged according to length of stay shows:

Length of Stay	Per Cent	Cumulative
1 day	18	18
2 days	10	28
3 days	10	38
4 days	12	50
5 days	11	61
6 days	7	68
7 days	5	73
8 days	5	78
9 days	4	82
10-13 days	8	90
14-20 days	5	95
21-30 days	3	98
31 days and over	2	100

PERSONNEL

Numbers. The average number of paid personnel is about 123, excluding residents, interns and students.

This amounts to an average of 170 full-time employes per 100 patients, 1.24 employes per bed, or 1.7 per occupied bed.

Job Vacancies. Three out of 4 hospitals reported job vacancies. Of those reporting vacancies, 1 in 3 had vacancies in graduate nurse positions. They averaged 6 such vacancies per hospital.

Of those hospitals having vacancies, 2 in 5 reported them in positions other than for graduate nurses. They averaged 5 such vacancies per hospital.

Governing Board. The average size of the governing board is 14 members.

Volunteers. One in 4 hospitals has volunteers other than women's auxiliaries. They average 37 such workers per hospital.

Women's Auxiliaries. More than one hospital in four has a women's auxiliary. The average membership of an auxiliary is 250, and it has 16 members working in the hospital.

Administrator. The chief administrative officer is a physician in 1 hospital in 14, a graduate nurse in 2 hospitals in 5. In almost one-half of the 100 bed general hospitals he is neither a physician nor a graduate nurse but has some other background.

In 1 hospital in 7 the administrator is a graduate of a college course in hospital administration.

In one-half of the hospitals the chief administrative officer is a male.

Other Categories. Three hospitals in 5 employ a qualified dietitian.

One hospital in 5 employs a graduate physical therapist; 1 hospital in 11 employs a nongraduate physical therapist.

About one-half of the hospitals employ a graduate medical record librarian; the remainder employ nongraduates.

One hospital in 20 employs a graduate medical social service worker. The

Table 2—Value of Perquisites

Perquisite	General Staff Nurse and Clerks	Practical Nurse and Untrained Pers.
Single room	$25.00	$18.50
Double room	18.50	12.50
One meal	14.00	12.00
Two meals	29.00	24.00
Three meals	43.50	36.00
Laundry	4.50	4.00

Table 3—Policies Covering X-Ray and Laboratory Charges

Inpatients	Lab. Charges	X-Ray Charges
Same to all	23 per cent	15 per cent
Only ward different	40 per cent	47 per cent
Different to all	32 per cent	40 per cent
Flat rate to all	4 per cent	.....
Clinic Patient		
Same as ward	38 per cent	42 per cent
Different from ward	52 per cent	51 per cent
Same as private	10 per cent	7 per cent
Private Ambulatory Patient		
Same as private patient	95 per cent	95 per cent
Same as semiprivate	3 per cent	5 per cent
Different for all	2 per cent	.....

Table 4—Usual Charges for Special Services

Service	Private Patient	Semi-private Patient	Ward Patient	Out-patient	Private Ambulatory Patient
Basal metabolism	$10	$10	$ 5	$ 5	$10
Electrocardiograph	$15	$15	$10	$ 5	$15
Cystoscopy	$15	$15	$ 5	$10	$15
Bronchoscopy	$10	$10	$10	$10	$10
Gastroscopy	$15	$10	$10	$10	$15
Tonsils and adenoids (Child flat rate)	$25	$25	$25	$20	$25

Table 5—Usual Charges for Operating Room and Anesthesia

Service	Private Patient	Semi-private Patient	Ward Patient
Operating Room			
Major	$30	$25	$15
Minor	$15	$15	$10
Anesthesia			
Major	$20	$20	$15
Minor	$10	$10	$10

same proportion (1 in 20) employs nongraduates.

One hospital in 33 employs a graduate occupational therapist, while only 1 in 70 employs a nongraduate.

Length of Employment. One hospital in 5 reports its nursing director as being employed for less than a year in that hospital, and 1 in 8 reports the administrator as being employed for less than a year.

SERVICES

Major. The following services are found in more than half of the existing 100 bed general hospitals.

X-ray diagnosis	97 hospitals in	100
Medical records department	9 hospitals in	10
Metabolism apparatus	9 hospitals in	10
Clinical laboratory	9 hospitals in	10
Electrocardiograph	9 hospitals in	10
Pharmacy department	3 hospitals in	5
Blood bank	3 hospitals in	5
Central supply	3 hospitals in	5
Medical library	3 hospitals in	5
Women's auxiliary	3 hospitals in	5
Outpatient department	1 hospital in	2

Additional. Services that might be provided but are generally found to occur in less than 50 per cent of the facilities are considered additional. The following indicates some of the services and the frequency with which they are provided within this hospital size and type group. Certain of these additional services may be provided through arrangements with other hospitals and sources.

X-ray therapy	2 hospitals in	5
Patient library service	almost 1 hospital in	2
Routine chest x-ray on admission	1 hospital in	6
Postoperative recovery room	1 hospital in	12
Children's educational program	1 hospital in	20
Physical therapy department	2 hospitals in	5
Social service department	1 hospital in	8
Occupational therapy department	1 hospital in	20
Cancer clinic	1 hospital in	4
Dental department	1 hospital in	6
Electroencephalograph	1 hospital in	14
Mental hygiene clinic	1 hospital in	20
Training course, auxiliary nursing personnel	1 hospital in	7
School of nursing	1 hospital in	3

DEPARTMENTS

Medical Staff. The average 100 bed general hospital has approximately 65 staff appointments. Of this number 27 are active, 6 associate, 20 courtesy, 8 consultant, 1 honorary and 2 other types of appointments.

More than 9 in 10 of these hospitals have a chief of staff. Almost 7 in 10 hospitals have chiefs of services. Forty-seven in 50 have a written set of regulations. Twenty-four in 25 have regularly scheduled meetings of the staff. Almost 22 in 25 have standing committees of the staff.

More than 4 hospitals in 5 have restrictions on staff physicians' surgical privileges. One hospital in 4 allows nonstaff members to practice in the hospital. One hospital in 3 provides examining rooms primarily for ambulatory patients of the medical staff. One hospital in 7 has physicians' offices for seeing private ambulatory patients in the hospital or on the hospital grounds.

Operating and Delivery Rooms. Hospitals average 3 to 4 operating rooms, 2 major and 1 to 2 minor. The chances are greater for having only 1 minor operating room.

The average number of operations approximates 1710 per year. Of this number 1030 are minor and 680 are major.

The 100 bed general hospital averages 1 delivery room and 2 labor rooms. One labor room may be set up to serve as another delivery room.

The average number of deliveries approximates 750 to 775 per year. Of this number 25 to 30 are by cesarean section.

Recovery Room. Only 1 hospital in 12 has a postoperative recovery room. Those that do average 4 such beds.

X-Ray. An average of 5500 x-ray examinations is given during the year, 1500 of which are for outpatients.

Eighty-six per cent of the hospitals have physician staff members specializing in radiology, 32 per cent have them full time, and 54 per cent part time.

More than 9 in 10 hospitals make x-ray facilities available to private ambulatory patients of physicians.

Laboratory. From 27,000 to 30,000 clinical laboratory examinations are performed during the year; 22,500 to 25,000 for inpatients and 4500 to 5000 for outpatients.

The ratio of these examinations to patient days of care is about 0.9 of an examination per patient day for inpatients.

Seventy-four per cent (3 in 4) of the hospitals have physician staff members specializing in pathology; 1 in 4 have them full time and half of the hospitals have them part time.

More than 9 in 10 hospitals have laboratory facilities available to private ambulatory patients of physicians.

Almost one-half of the hospitals (47 per cent) have all tissues removed in surgery routinely examined by a pathologist.

Blood Bank. Three hospitals in 5 have a blood bank. Those hospitals having blood banks issue 522 units of 500 cc. each per year. This amounts to an average of 5.23 units per bed per year. Their average stock amounts to 17 to 18 units. Their bleeding capacity is 3. Their blood supply is obtained as follows: 68 per cent from donors, 3½ per cent from other hospi-

tals, 8 per cent from nonhospital sources, and 20½ per cent from Red Cross centers.

Nursing. Almost one-half (48 per cent) of the nursing staff is nonprofessional, such as practical nurses, nurse's aides and attendants. If the hospital has a nursing school the proportion is reduced slightly to 43 per cent.

Dietary. An average of about 120,000 to 125,000 meals is served annually; 80,000 to patients and 40,000 to 45,000 to employes and other persons.

More than 3 in 5 of the hospitals employ a qualified dietitian. In those hospitals that do employ dietitians, they average 2 such persons per hospital.

Four hospitals in 5 use gas for cooking.

Almost 4 hospitals in 5 have mechanical centralized dishwashing service; 1 hospital in 10 has manual and decentralized dishwashing service; 1 hospital in 12 has manual and centralized service; and 1 hospital in 12 has a mechanical decentralized dishwashing service.

Almost 4 hospitals in 5 have a centralized food service.

Only 1 hospital in 4 has selective menus for all patients, and 1 hospital in 6 has selective menus for private patients only. More than half of these hospitals do not have selective menus.

Raw food accounts for between 55 and 60 per cent of dietary costs.

Laundry. Seven hospitals in 10 operate their own laundry. Those that do average 1 employe for every 13 or 14 hospital beds, or 7 to 8 employes per hospital. In these hospitals the laundry processes around 400,000 pounds, or 875,000 pieces per year.

Hospitals operating laundries have an average water consumption of 11,835 cubic feet per bed per year; those not operating laundries average 9277 cubic feet per bed per year.

Plant Operation. Most hospitals use coal, with oil ranking second and gas third, as the type of fuel used for general heating.

Ambulance. Four in 5 hospitals provide or arrange for ambulance service.

Approximately 1 in 12 own and operate their own ambulance; 1 in 6 use city or publicly owned ambulances, and 7 in 10 general hospitals use private nonhospital ambulances.

FINANCIAL

Assets. Total assets per bed: $8000.

Plant assets per bed amount to $5500, or 68 per cent of total assets.

Replacement Funds. Two in 5 hospitals indicate a need for funds for replacement of obsolete equipment and service departments including replacement or expansion of service utilities and replacement but not expansion of bed complement. This need amounted to approximately $325,000 to $350,000 per 100 bed general hospital.

Expenses. Expenses per hospital bed per year approximated $460,000 to $480,000.

Expenses per patient day averaged $17.75, varying from $22 to $23 for private patients, $18 to $19 for semiprivate patients, and $16 to $17 for ward patients.

Average expenses per patient stay amounted to $125.

Pay Roll. Average annual pay roll amounted to $255,000 to $265,000. Average annual salary per employe approximated $2075 to $2120. Average annual salary of administrator approximated $7500.

Average starting salary per month amounted to $218 for general duty nurses, $152 for practical nurses, $124 for untrained women, $145 for untrained men, and $151 for clerks.

Pay roll amounted to about $9.80 per patient day, or 55 per cent of total expenditures.

Perquisites. The value of perquisites per month varied as shown in Table 2 for general staff nurses and clerks and practical nurses and untrained personnel.

Departmental Expense. The departmental breakdown of expense shows the following figures:

Administration	10-11	per cent
Dietary	15	per cent
Housekeeping	5	per cent
Laundry	3	per cent
Plant operation	7	per cent
Medical and surgical	6	per cent
Operating and delivery room	6-7	per cent
Pharmacy	5-6	per cent
Nursing	26-27	per cent
Anesthesia	2	per cent
Laboratory	5	per cent
X-ray	5	per cent
Other	3	per cent

Income. Patient income for the year approximates $440,000 to $455,000. Patient income per patient day averaged almost $17 ($16.85), varying from $28 to $29 for private patients, $22 to $23 for semiprivate patients, and $12 to $13 for ward patients.

Average patient income per patient stay amounted to $115 to $120.

Patient income amounted to $16.85 per patient day, or about 95 per cent of total expenses.

Room Charges. Generally speaking, hospital charges for room, board and routine services do not cover the cost of providing such care.

The average daily room charge amounted to $11.25 for single rooms, $9 for 2 person rooms, and $7.50 for multiperson rooms.

Laboratory and X-Ray Charges. The policies shown in Table 3 cover the making of x-ray and laboratory charges in hospitals.

The general practice for laboratory service is to charge private patients a higher rate than semiprivate; to charge semiprivate patients a higher rate than ward; to charge ward patients a higher rate than outpatients, and to charge private ambulatory patients a rate comparable to that for private inpatients.

The charges shown in Table 4 are the most usual charges for certain special services.

Operating Room and Anesthesia Charges. The most usual charges for operating room and anesthesia services are shown in Table 5.

Drugs. Three in 4 hospitals charge for drugs carried on the nursing unit.

OTHER INFORMATION

Injuries. The 100 bed general hospital can expect 21 employe injuries per year. The average loss per injury amounts to $400, or $8000 per year for all injuries.

Of the 21 injuries, 4 are caused by sprains, 4 by falls, 3 by handling material or equipment, 2 because of unsafe practices, and 8 for other reasons.

The average time lost per injury amounts to 11 days, or a total loss of 231 days per year. Nursing personnel accounts for 97 of those days.

SOURCES OF INFORMATION

American Hospital Association, Administrator's Guide issues.

Hospitals, journal of the American Hospital Association.

The MODERN HOSPITAL.

Hospital Progress, journal of the Catholic Hospital Association.

Hospital Management.

United Hospital Fund of New York, special bulletins.

Rochester Regional Hospital Council, Rochester, N.Y.

The Duke Endowment, Charlotte, N.C.

Philadelphia Hospital Council.

Various state reports on analyses of services rendered in hospitals built under the Hospital Survey and Construction Program (Georgia, Illinois, Texas, Ohio).

Vital Statistics of the United States, Reports of the National Office of Vital Statistics, Public Health Service, Department of Health, Education, and Welfare.

How Does Your Nursery Rate?

Part II

HELEN C. LATHAM, R.N.
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CARE OF BABY IN DELIVERY ROOM

IN THIS section are discussed the following factors in the baby's care: care of cord, methods of keeping baby warm; at weighing, temperature taking and bath, and transportation to the nursery.

Cord: The American Academy of Pediatrics * recommends that the cord dressing and umbilical area be kept clean and that if a cord dressing is used it should be kept in place by a binder of soft sterilized gauze.

The survey shows several kinds of differences in the care of the cord. Fourteen report no dressing over the cord (just a clamp or tie) while nine hospitals report using a dressing 20 hours after birth; one, 12 hours; three, 48 hours, and one for only a few days. Almost one-third of the hospitals use a dry sponge and belly-binder (23 hospitals) while 15 use an alcohol dressing, and nine hospitals each use something other than that. More than one-third of the hospitals (33) report using alcohol to cleanse the cord, while 31 report no cleansing of the cord.

Added Heat: For warmth of the baby following delivery, the recommendation is that there be a "smooth flannel blanket, in a sterile package, warmed and ready to receive the infant at birth. A heat lamp on a standard is helpful in keeping the infant warm."

This survey revealed that 69 of the 83 hospitals did provide extra heat for baby. Of these 69, three hospitals specified using an incubator and 57 said "heated bed."

Weighing and Temperature Taking: In view of the concern about keeping the baby warm, the question may be raised of how necessary it is to weigh the baby within an hour of his birth as seems the common practice (72 hospitals out of 83 did this). Also, if there is concern about the warmth of the baby, why do some hospitals report taking the initial temperature anywhere from one to 18 hours after birth? (Only 60 out of 83 hospitals took the temperature within an hour after birth; that is, more hospitals weighed the baby in his first hour than took his temperature.) It is interesting to note that one hospital keeps the baby in a heated crib for 12 hours, while another hospital places the baby in heated crib, but takes the baby's temperature every two hours until it is normal twice, then removes him from external heat.

Transportation to Nursery: Sixty-one of the 83 hospitals transport the baby from the delivery room to the nursery in the nurse's arms. Only nine report using a heated bed. This is not entirely opposed to the recommendation which states that "a heated bed or a warm carrier (sometimes called a 'hand ambulance') be used for transfer of the patient. If the infant is carried by a nurse he should be wrapped in a warm blanket——."

Initial Bath: Still relative to warmth of the baby, the question may be raised as to why more than half the hospitals still give the baby a complete bath following delivery (20 hospitals say "entire body" and 22 say "shampoo and entire body"). Only four hospitals report cleansing just obvious soil (blood, meconium and mucous). Three hospitals wait 12 hours before bathing baby. Of five that report that no initial bath is given, one would like to know if obvious soil as blood and meconium are removed immediately in the delivery room.

In all, 16 different solutions were used to cleanse the baby. Of these, oil was the commonest with soap and water next in frequency.

DAILY CARE OF BABY

This section includes a discussion of mother-baby contact, skin care, frequency of temperature taking, and linen and clothing of baby.

Mother-Baby Contact: Mothers who breast feed babies have frequent contact with their babies, but what about bottle-fed babies? More than half the hospitals (54) let the nonnursing mother hold the baby at the usual feeding time. (It is assumed that the mother gives the baby its formula then.) A few hospitals (5) let the mother have the baby only twice a day, while 14 permitted it merely daily. Others said mothers hold the baby at the usual feeding time except at night.

The Academy of Pediatrics recommends that the "practice should be encouraged for permitting the mother to give the bottle to her infant." The question may be raised as to why all hospitals do not have the nonnursing mother give her baby its bottle, at least during the day.

It might be pointed out that if babies were left with their mothers at feeding time in the morning, most of the nursery housekeeping could be done then—probably more safely and adequately than when the babies are in the nursery. Also, the baby's position could be changed more frequently. From the psychological point of view of the baby, would not he eat better if he were held and cuddled by his mother during feeding time?

Skin Care: In regard to care of the skin, the American Academy of Pediatrics states: "The proper care of the skin of newborn infants is important in preventing infection. At present the concensus seems to be that the less manipulation the less danger of infection. It is recommended that no water or oil bath be given during the

This article, which is an excerpt from an unpublished survey "Current Practices in the Care of the Newborn," written by Miss Latham in 1951, has been presented in two sections. Part 1 appeared in the September issue of this magazine.

*American Academy of Pediatrics Committee on Fetus and Newborn, "Standards and Recommendations for Hospital Care of Newborn Infants."

first week or 10 days after birth. The Vernix may be gently wiped away from the folds of the infant's skin with warm sterile mineral oil on sterile cotton or soft sterile gauze. Each time the diaper is changed sterile oil should be applied to the soiled or wet areas of the skin."

The survey showed that the number who gave the baby a complete bath exceeded by a small margin those that gave the baby a partial bath. Only five hospitals reported cleansing the baby "as necessary." How satisfactory these five hospitals found this practice was not asked.

As to type of solution, the majority of the hospitals (34 out of 83) used water, with oil a close second in popularity (22 hospitals). Soap and water was used by 15 hospitals. Fifteen of the hospitals used two different strengths of alcohol and of benzalkonium was used by varying hospitals. Boric acid is mentioned by two hospitals.

COMMENTS OF SUPERVISORS

Perhaps comments of obstetrical supervisors in answering the questionnaires relative to skin care of babies should be considered. One obstetrical supervisor wrote: "Cleansing of the baby varies with the individual attending physicians. Some do not want baby bathed until discharged except to cleanse buttocks. . . . Others want water only, while some say soap and water. Some oil immediately following birth. Routine orders for each attending are kept in the nursery." Another said that in the event of excoriated buttocks, sterile water was used for cleansing, buttocks were thoroughly dried, and zinc oxide ointment was applied at each diapering. (This hospital usually used oil to cleanse buttocks.) Another explained that if an oil rash was present, the creases were cleansed with boric, then oil applied. Another wrote, "Oil is little used in this climate, most of the physicians think it is too warm for it." Still another supervisor said, "There have been few rashes since using lotion." And still another supervisor explained that, although lotion was used, water was substituted if a rash was present.

Care of Buttocks: The care of the infant's skin in current practice is further complicated by the array of solutions of ointments (17) used on the buttocks after the baby is diapered. Water was most frequently used, oil was next, and lotion third in popularity. Normal saline, boric and two different strengths of benzalkonium were used for cleansing purposes.

Weighing and Taking Temperature: Weighing the baby has already been discussed under Part 2: "Special Measures for Prevention of Infection." Of note is the fact that more than half the hospitals (55) weigh the baby daily. The fact that the majority (72) take baby's temperature rectally in contrast to the recommendation of axillary temperature has likewise been discussed. In addition to this, there is a wide variability in the frequency of temperature taking. A few more hospitals reported taking the temperature bi-daily. The hospital that reported taking the temperature on admission and on discharge represents the most extreme practice, while the hospitals where the practice was to take the temperature only the first 48 hours unless there were untoward signs and symptoms are perhaps the next most extreme.

In regard to frequency, the recommendation is "That in suitable cases (normal infants) the temperature be taken not oftener than twice a day."

Linen: In the care of the linen, the Academy of Pediatrics states that "if possible, all gowns, caps, masks, infants' wearing apparel and linen, and all other equipment that comes in contact with the infant should be sterilized. However, the shortage of personnel, equipment and space makes this recommendation impractical if not impossible. As a compromise it can be assumed that the material that comes out of a modern hospital laundry is sterile for all practical purposes. All laundry coming from suspect and isolated nurseries should be autoclaved. Great care should be exercised to prevent contamination of clean linen in the nursery."

For soiled linen, the recommendation is that diapers and other soiled nursery linen should be washed separately from each other and from other hospital linen.

The survey revealed that 46, or a little more than half the hospitals, used sterile linen. A further analysis of the data showed that 30 hospitals did not use sterile clothing or sterile linen, and that 19 hospitals did not wash new nursery linen before using it.

As the survey progressed, certain limitations were seen. No information had been obtained about the conduct of visiting hours (for example, limiting visitors to husband), provision for isolation of a baby or a mother with signs of infection or mother who has been exposed to infection, or discussion of perineal care of the mother or assignment of nurse to clean and isolated babies. These are all related to the subject of prevention of infection to the baby. More information about health practices of personnel, such as chest x-ray examination after reporting back from a vacation or illness and keeping employes on duty when they have colds, would have been helpful.

The standards set up by the American Academy of Pediatrics in 1948 are by no means accepted by hospitals and fully carried out yet. The variability of almost any single practice in the care of the newborn seems to point to a lack of criteria of scientific information, a lack of understanding of objectives, and a lack of joint planning and evaluation of procedure by medical and nursing staff. Studies might be done on almost any technic used: handwashing technic, use of throat cultures in prevention of infection, criteria by which to judge which solutions should be used not only in the care of the baby but in housekeeping; care of soiled formula bottle nipples, frequency of taking temperature, and others.

The use of boric acid in a maternity department seems questionable, as does using new linen in the nursery before it is washed. Current literature points out the danger of these practices.

MINORITY ON RIGHT TRACK

In many instances, what a few hospitals are doing may be interpreted as a trend rather than what the majority is doing. What the minority is doing seems more reasonable and in line with recommendations of the American Academy of Pediatrics, such as no dressing over the cord, only 10 babies in a unit, masks for everyone entering the nursery except nurses, washing hands on first entering the nursery, cleansing mothers' breasts at bath time only, washing only obvious soil from baby at birth, weighing baby every other day, and taking axillary temperatures.

Finally, there appears to be a need for the doctor, the nurse, the nutritionist, the housekeeper, the hospital administrator, the psychiatrist and the pathologist to unify their efforts so that the baby receives both consistent and optimum care.

This inventory makes it possible to

MEASURE WORKERS' ATTITUDES

THOMAS CALERO
Research Assistant, The Industrial Relations Center, University of Chicago

WHAT do our employes really think about their jobs, their working conditions, their pay? Do they think the hospital operates efficiently? Do they care about the hospital's success? What suggestions and criticisms do they have and what use can we make of them?

These are a few of the questions that many administrators are asking themselves today. They are revealing of the decreased emphasis on technical, mechanical analyses of operating problems. They are evidence for the belief that organizational efficiency has come to depend more and more upon satisfied employes.

How can we tell if employes are satisfied? Can supervisors tell us? Can we get at this through a suggestion system? How can we determine whether our employes are more or less satisfied than are those of other companies? Can we depend on employe analysis of the situation? If so, how do we go about "doing something"?

These questions sketch the probable line of thought taken by most hospital administrators who have decided a knowledge of employe opinion is worth having. They also indicate one aspect of the line of thought behind the development of the SRA Employe Inventory.*

The reasons for this parallel thinking are not hard to find. In brief, the SRA Employe Inventory is an opinion survey procedure that seeks answers to questions such as the foregoing, or, in other words, provides a measurement of employe opinion toward the work environment. It is the product of a joint research endeavor between business organizations and the Industrial Relations Center at the University of Chicago. It grew out of the interest of modern managers in ways to assess employe opinion and out of the desires of the university group to conduct employe opinion research in business situations.

The Employe Inventory makes possible the systematic canvass of employe opinion with respect to all the important aspects of work and provides an analytic procedure for putting this information into useful, understandable form. It has been used to gather and analyze the opinions of employes in a wide variety of organizations.

The last 20 years has seen a marked general increase in human relations research activity. Considerable critical thinking and experimentation have gone into such things as supervisory training, economic education, personnel policy, and communication procedures, as well as into opinion and attitude investigations.

The Employe Inventory may be said to represent the convergence of two main streams of research activity within the context of this increased general interest in human relations. One stream of research activity has been carried on by the market analysts and public opinion pollsters. At the same time, psychologists have carried on rigorous investigations into the nature and measurement of attitudes (*e.g.* the racial, religious and political attitudes of many groups of people).

The other principal source of our knowledge about and understanding of opinions and attitudes has come from industrial studies by anthropologists and sociologists. These studies aim at an understanding of particular attitudes and opinions as they are expressed in the over-all situation of which they are a part. It is in this way that many industrial studies treated particular aspects of job satisfaction—that is, in terms of the whole work situation. Nondirective interviewing was often the principal research method used in these studies. This interviewing was shown to provide a great deal of useful information but also a great deal of irrelevant and noncomparable information. On the other hand, some of the questionnaire methods employed by market analysts and opinion pollsters have been shown to be too cryptic and lacking in necessary background information.

About four years ago, because of the growing recognition of the value of questionnaires in assessing the attitudes of employes, Sears, Roebuck & Co., which had pioneered in the field, decided to conduct extensive research in the questionnaire type of survey and to develop a questionnaire which would be more extensive, cover more areas, and be more reliable. Sears' forces were combined with the Industrial Relations Center, which was also interested in developing such a questionnaire, and with interested business organizations in undertaking this research task. Experienced research people from psychometrics, from the social sciences, and from business organizations were brought together in this endeavor. The results were the SRA Employe Inventory.

CONTENT OF EMPLOYE INVENTORY

The format of the Employe Inventory can be briefly described. It is made up of 78 statements. Some of these are:

Poor working conditions keep me from doing my best in my work.

I can learn a great deal on my present job.

I am paid fairly compared with other employes.

To each of these statements employes are asked to answer "Agree,"

*Published by Science Research Associates, 57 West Grand Avenue, Chicago 10. Copyright by the Industrial Relations Center, University of Chicago, 1951. All rights reserved.

"Disagree," or "Undecided" on a standard answer sheet. Tabulation of the answers given by an employe will reveal those things that he considers satisfactory and unsatisfactory about his job. Tabulation of the answers for an employe group will reveal the positive and negative aspects as seen by that group.

The statements that appear in the Employe Inventory were selected after a long process of investigation and trial runs. In their present form they are designed to cover the major aspects of the job and company about which employes may be expected to have opinions. These aspects in brief are: immediate job activities, working conditions, financial rewards, relations among employes, supervisors and higher management representatives, company operating efficiency, and personal satisfactions. The 78 statements are written so that they inquire into one or another specific aspect of the "facts of life" about an organization. For example, six statements inquire into working conditions, four into pay, five into operating efficiency of the company, and so on.

Special statements may be added by the individual hospital if it is desired to investigate specific local issues. Examples of such special statements are.

Prices in the cafeteria are about right.

Lots of the material I work with is below standard quality.

Clothing and laundry allowances are about right.

The way work assignments are made has improved a lot over the past couple of years.

To each of these special statements employes are asked to answer "Agree," "Disagree" or "Undecided" just the same as was done for the standard statements.

The format of the Employe Inventory encourages the expression of additional opinions. A special page is provided on which employes may write out any elaboration of their opinions that they care to express. Since at no time is an employe asked to sign his name or to identify himself personally during the survey there is no reason for him to hesitate about writing a comment. These comments are then transcribed to master lists and classified by subject matter. They are a valuable source of raw material since they add local flavor and sharpness to the analysis of survey results.

ANALYSIS OF SURVEY RESULTS

Probably the best way to describe the manner in which the information gathered from a survey is analyzed is by means of illustration. Take the case of a medium-sized hospital that was surveyed. It was logical in this instance to break the survey results into a number of departmental groupings—x-ray, laboratory, business office, dietary, medical staff, housekeeping, and the various nursing services. In order to do this each employe participating in the survey was asked to put a letter on his answer sheet that would indicate the department in which he or she worked. In each case employes also were asked to record whether or not they were members of the supervisory force (this means it is possible to differentiate between first-line, middle and top management people depending on the wishes of the hospital concerned).

After the survey information was complete the Industrial Relations Center staff tabulated the answers into their appropriate departmental groupings. A series of scores was thus obtained for each group. For instance, 41 per cent of the people in one of the nursing services agreed that "My supervisor sees that employes are properly trained for their jobs," only 32 per cent agreed that "The pay here is lower than in other companies," and 72 per cent said, "For my kind of job the working conditions are O.K." This was done for each of the statements on the Employe Inventory for each of the departmental groups included in the survey. These scores were then placed into statistical tables for use in analysis and for making comparisons between groups.

Next, profile charts were prepared. The profile chart is essentially a scal-

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We Tried the Inventory— and It Works!

A. STUART KELSEY
Taunton, Mass.

I THINK I can now make myself better liked—easier to work with and for." "I've learned how to understand people better; am more aware of how to treat certain types of personality and how to get the best work from them." "I have gained self-confidence." "I have a more accurate knowledge of how other supervisors think, their reactions, their feelings on common problems and how they handle these." "Our free discussions have brought us closer together . . . has done much to improve understanding between departments."

What kind of a supervisory training program can awaken such diverse response? An understanding of others' thinking, appreciation of others' point of view, self-analysis, an awareness of communication, coordinate teamwork. How was the program evolved? How planned? How presented? Let's trace through these stages.

Stimulation came from two directions. You may have participated in a management survey of personnel practices conducted by the American Hospital Association. In which case, you were told just where you stood on various personnel functions and practices in relation to established hospital norms. The A.H.A. specialists indicated that there are two glaringly weak areas in our hospital—merit rating and orientation and training. Only 11 per cent of the hospitals surveyed were poorer in these areas, and 77 per cent were above us. This was quite a jolt.

ing device on which are plotted the various scores resulting from the survey. The scale used has a "very high" and a "very low" end with graduations of intensity in between. When a chart is prepared for any one group or department the tone and intensity of various employe attitudes may be graphically portrayed.

In the instance of the nursing service group it was possible to tell at a glance that pride and interest in the work, adequate working conditions, and friendly co-workers were the principal satisfactions these people derived from their work. On the other hand, it could be seen that these people were very dissatisfied with their work load and consequent fatigue, with relations with their supervisors, and with work assignments.

These things can be considered as the strengths and weaknesses of the work situation as seen by these nurses. The remaining attitudes they expressed fell between these two extremes. As far as the director of nurses was concerned, then, the places for and kinds of corrective action appropriate for these people were sharply brought out by the survey profile analysis.

The profile method has a number of further uses. For instance, results for two or more departments may be plotted on the same profile chart and compared. A departmental group may also be compared with the divisional (or larger) group of which it is a part. For example, a nursing service can be compared with an over-all average for all nurses in the hospital. Any department or larger organizational unit may be compared with the over-all hospital profile in the same fashion. These comparisons point up the departments or other groups that may be considered "problems" and bring into focus any "problems" that are hospital-wide in scope. Groups may then be studied more closely to determine the reasons behind the problems expressed. Of course, it is of equal value to note the reasons for the high morale of other groups or departments.

Making further use of illustration, we see clearly on the basis of the survey that the hospital under discussion had at least two general problems on its hands. One was general efficiency and the other was communications procedures. With respect to operating efficiency many employes backed up their unfavorable opinions (as recorded on the Employe Inventory statements) with written comments. A few of these were:

"Changes are made in office procedures without any advance notice to those people whose work is affected."

"Cooperation between departments would be better if each department understood the ways and procedures of other departments."

"Nursing care on our floor is made more difficult because patients' records are not kept properly. Often I don't know if medications have been given or if the attending man has been there. . . ."

"Equipment we have is often not clean, in poor repair, or not in operating condition. Needles are a big headache."

A few of the dissatisfactions with communication were:

"There should be much closer contact between medical staff and nursing service."

"You can't find out what's going on around here even if you ask."

"Lots of the new people quit because of confusion in getting used to the job. There's no system for getting information."

"Director of nurses should pass on some of her experience to guide lower supervisors."

ACTION AND FOLLOW-THROUGH

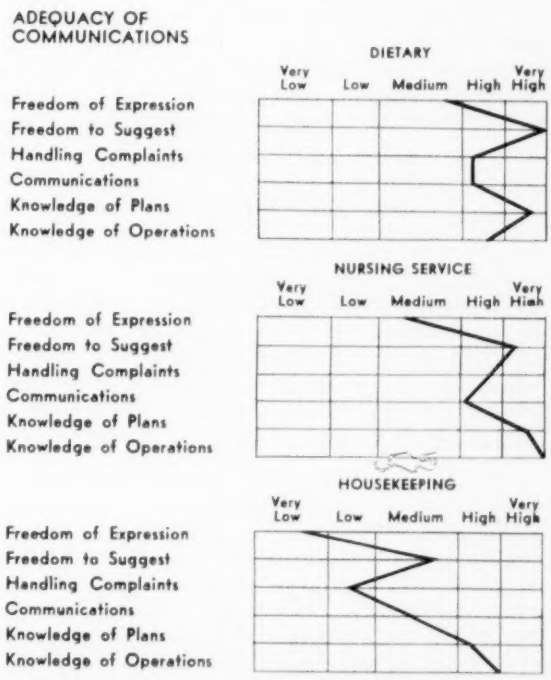
In a very real sense the Employe Inventory process only begins with the submission of the survey results to management. The information provided by the survey is a systematic frame of reference to which management, supervisors and employes should contribute their specific knowledge and insight. This is essential in order that the "problems" coming out of the survey take on specific local meaning and that

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As far as merit rating was concerned, management had anticipated the situation. The survey just hurried things along. Four somewhat different approaches had been tested. Supervisors acted as guinea pigs. They tried each system in practice, suggested changes, and actually determined the final form they wished to use. By this time, there was no question of having to sell supervisors on the desirability of such a program. They had gone through the thought processes of building their own system. They understood the whys and hows. Only then did we conduct two training sessions so as to coordinate the use and application of the plan.

The second stimulant came from a periodic routine employe opinion survey. You know, of course, or have heard of the favorable morale effects afforded by such surveys, of the positive guides they furnish in molding policy. We are concerned here with how the survey was used in pointing up training needs.

In this case, we used the Employe Inventory as sponsored by the Industrial Relations Center of the University of Chicago and supplied by Science Research Associates. It is an inexpensive, self-scoring questionnaire for measuring employe attitudes. It is particularly useful because it develops meaningful scores in 14 categories, permits intergroup comparisons, lends itself to graphic summary, permits each category to be broken down for intimate analysis,



the reasons behind the "problems" may be systematically evaluated. Only after this pooling of effort has taken place can corrective action appropriately begin.

This hospital began the action phase of the survey process by means of a series of conferences at the top, middle and lower supervisory levels of the organization. At these conferences the results of the survey that particularly applied to the people on hand were presented in a discussion format. Each supervisory person was then encouraged to study the results carefully and to add his ideas and comments to the survey analysis. The pooled ideas and comments of appropriate supervisory groups then became the outlines for problem-solving sessions. (This procedure is typical, and eminently useful, in the survey follow-through.)

On the basis of this activity the supervisor and his assistants of one office department undertook a systematic study of work flow and work assignments to meet the objection from employes that work flow was too erratic and work load poorly distributed. This study and the consequent revised practices led to significant improvement in employe job satisfaction.

Turnover in personnel was one of the general problems of the nursing services. Nurses found themselves working with nurses trained in a number of other hospitals. Each brought to her new job former ideas and points of view. This caused bickering within nursing units and was one aspect of poor supervisor, head nurse, graduate

SAMPLE INVENTORY QUESTIONS

	AGREE	?	DISAGREE
1. The hours of work here are O.K.	☐	☐	☐
2. Management does everything possible to prevent accidents in our work	☐	☐	☐
3. Management is doing its best to give us good working conditions	☐	☐	☐
4. In my opinion, the pay here is lower than in other companies	☐	☐	☐
5. They should do a better job of handling pay matters here	☐	☐	☐
6. I understand what the company benefit program provides for employes	☐	☐	☐
7. The people I work with help each other out when someone falls behind or gets in a tight spot	☐	☐	☐
8. My boss is too interested in his own success to care about the needs of employes	☐	☐	☐

and, most important, is as reliable for as small a group as 10 as the scores on the best designed individual psychological tests. The Employe Inventory is perhaps the most pregnant tool that has been devised for management help in the personnel function.

It may be said that the scores on the Employe Inventory exhibited a uniform high regard for supervision, excellent interpersonal relations, and very high opinion of technical competence. Such favorable employe appraisal was a tribute both to the caliber of supervision and to a planned campaign in human relations. It must be admitted that such basic empathy between worker and boss gave a most fortunate base to work on.

Suppose we look at a few indicators uncovered by the Employe Inventory, as summarized in Table 1 and the accompanying graph. Some of the results look pretty sad,

Table 1—Results of Employe Inventory

	Per Cent of Favorable Replies				
				Supervision	
Area	*Dietary*	*House-keeping*	*Nursing Service*	*Nursing*	*Service & Admin.*
Adequacy of personnel program	94	100	45	70	95
Method of handling complaints	70	75	30	75	90
Freedom of expression	65	50	20	75	80
Freedom to offer suggestions	100	90	65	95	100
Down-the-line communications	75	75	50	95	80

don't they? Remember, they popped up in an organization with "progressive" policies, in an organization in which management has a considered policy of emphasis on the emotional incentives. There is a lesson here. Management simply does not know, cannot know what its people are thinking without using survey methods.

From these and other signs, it appeared there was probably little wrong with fundamental policies. Discrepancies were in application of policy in different work groups and levels. Significantly, unfavorably low ratings were found in the professional nursing group. Strangely enough, the nonprofessional worker in the nursing service was consistently and considerably more favorable in her attitudes than was the professional.

Scores in many areas were spotty—good, bad and indifferent. But the value of this type of survey was demonstrated by the actual pinpointing of weak areas and the intensity of feelings. By and large, pride in the job was not what it should be; people didn't see their jobs as particularly important; there was poor personal integration with the hospital as a whole. Too many people just didn't know where they stood with the job, with the boss, or with the institution. The latter factors spoke for an orientation program.

Communications were questionable. Grievance procedure needed revitalizing. Statistical treatment of the Employe Inventory scores showed communications as having high positive relationship with status and security. Status and security showed excellent correlation with each other and individually with morale. There was an uncommonly high correlation between morale and communications.

When the vital importance of communications became so impressive, Administration began to look on progress rating from a new angle. Rather than seeing it as a mere check on progress—"Does she rate a raise?"—executives began to see the chance to use the program for better communications. It was a vehicle to force supervision to make an objective study of the employe, a tool to help the supervisor prepare for periodic evaluation interviews with her people. So it appeared desirable to work interviewing technics into the development program. This, in turn, suggested more advanced consideration of why people are different, or their personality qualities.

It was decided that the training agenda should include:

SAMPLE INVENTORY QUESTIONS

	AGREE	?	DISAGREE
9. My boss is always breathing down our necks; he watches us too closely	☐	☐	☐
10. My boss gives us credit and praise for work well done	☐	☐	☐
11. Management here does everything it can to see that employes get a fair break on the job	☐	☐	☐
12. If I have a complaint to make, I feel free to talk to someone up-the-line	☐	☐	☐
13. My boss sees that employes are properly trained for their jobs	☐	☐	☐
14. My boss sees that we have the things we need to do our jobs	☐	☐	☐
15. Management here is really trying to build the organization and make it successful	☐	☐	☐
16. Management here sees to it that there is cooperation between departments	☐	☐	☐

nurse relations. The nursing director, working with supervisors and head nurses, devised a systematic orientation program for new nursing personnel and arranged for the publication of an up-to-date manual of regulations and procedures. Graduate nurses were encouraged to contribute their ideas and experience to the manual and to assist in keeping it abreast of developments.

In one laboratory the number of criticisms arising from the survey led to real soul-searching and a review of the whole basis for existing standards and procedures. This led, of necessity, to conferences with the departments with which the laboratory comes in contact. Certain revisions of practice were indicated and these were put into practice on a experimental basis.

These specific departmental actions illustrate (1) how the effectiveness of departmental operation was improved and (2) how such measures fitted into corrective action on over-all hospital problems. The operating deficiencies and communications flaws which the Employe Inventory revealed as the most serious hospital problems were attacked by the actions of specific departmental groups as well as by interdepartmental cooperation.

This article has sketched the history and development of the SRA Employe Inventory, the format and content of this inventory, and the manner in which survey results are analyzed. In a subsequent article the actual procedures followed in setting up an inventory survey, in conducting the survey, and in publishing the survey results will be systematically described.

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1. A refresher on job relations (TWI).
2. Development of an orientation program.
3. A refresher course on handling of grievances.
4. Interviewing technics.
5. Fundamentals of emotional security.
6. A study of primary temperament qualities.
7. Throughout the series, a hammering home of an awareness of communications and their implications.

Human relations is most adeptly treated through the conference method. The upper echelons of our supervision were fully experienced in group discussion. Over a period of time, they had developed their own leadership. A second group was formed of those newly arrived on the job and those who had not previously participated. Thus, every person in any supervisory capacity was included in the program. This junior group was to consider Items 1, 2 and 6. In addition, it would discuss correcting mistakes, handling praise, grievances, making changes, and giving orders.

So much for the planning. How did the program work out? Well, let's follow just the matter of orientation as it was developed by the experienced group. Here was something that management wanted. Up to now, each supervisor did what she saw fit in introducing a new person to the job and the hospital. The subject was introduced to the conference group as a problem that needed its help. The word "orientation" was never mentioned. Survey facts and figures were related: the lack of pride in the job, absence of feeling of status or job importance, no realization of what the job meant in the over-all operation of the hospital, no real feelings of its being "my hospital." The group was brought to the realization and acknowledgment that we had a problem.

The leader mentioned, as though in passing, that lost feeling, the most lonesome day in life—the first day on a new job. Then a lead question: "Let's look back. What was done for you on your first day here?"

Personal experiences tumbled out. Then discussion turned to what supervisors wished they had been told but were not: things they felt any new supervisor should know about the job, the organization, policies, personalities.

"And so what do you do for your own new employes?" Items in common practice were listed. Many variations came to light. "Well, that's good. I ought to tell my folks that, too." "These are all important." "Let's make a check list so we'll all be doing the same thing."

So they built a check list, determined its wording, how it should be used, which items should be handled by the employment office, which by the immediate supervisor. "O.K., let's have the check list mimeographed and start using it right away."

LEADER: Whoa! Not so fast! Suppose we summarize: It appears that you have recognized a problem. You have dug out the things you are already doing about it. You've added certain ideas you feel should be done. You have decided who should do them, how and when. You have devised a check list to ensure uniform treatment. Now are you just talking or are you convinced this is it?" *(Overt resentment is shown because their sincerity has been questioned. General agreement that the program is a must.)*

LEADER: Pardon my question but this is the first time a thing like this has happened and no one has groaned about the time it's going to take. How come?" *(Period of silence as the group thinks that over.)*

MEMBER K *(hesitatingly)*: Well, I think we've seen that a pretty serious situation does exist. If doing these things will help morale, as it is reasonable to expect, I'm for it no matter how much time it takes.

MEMBER S: I don't see it that way at all. As it is now, I get a new orderly sent over to me. I spend some time with him anyway telling the few things I have thought were necessary. I get someone to show him the ropes. Sure, I've tried to keep friendly relationships in my group, but I kinda let teamwork take care of itself. The guy quits

(Continued on Page 144)



BENJAMIN RUSH
(1745-1813)

They Made Hospital History

BENJAMIN RUSH

Part II

OTHO F. BALL, M.D.

BENJAMIN RUSH now concerned himself with a rapidly growing practice and delved into new struggles of the times, antislavery, temperance and prison reform, and spent much of his energy in establishing Dickinson College at Carlisle, Pa.

As a teacher, he had the respect and affection of his students. Through them and his books he exerted a considerable influence on medical practice of that era. Meigs wrote of him, "I was enrapt, his voice sweeter than any flute, fell on my ears like droppings from a sanctuary, and the spectacle of his beautiful radiant countenance, with his earnest, most sincere, most persuasive accents, sunk so deep into my heart that neither time nor change could eradicate them."[2] To serve an apprenticeship under Rush became a special privilege. Applicants were many and to keep the number down to six, he charged a high fee.

His consultations began to decline about 1789, for the local physicians were largely royalists and, moreover, he tried to impose his medical theories and they refused to accept them. A great deal of his practice was among the newcomers. After the great epidemic of 1793 and Rush's battle with the other physicians, his practice greatly declined.

In the meantime he had established the Dispensary and had been a founder of the College of Physicians of Philadelphia. At that time (1785) there were 45 physicians and surgeons in that city. At first he was one of the most active members of the society but six years after its founding, when prominent members violently opposed his methods in dealing with the yellow fever epidemic, he resigned. With his resignation he sent a set of Sydenham's books as a rebuke for their ignorance.

In 1791 Rush appealed through the newspapers for a separate building for the insane at the Pennsylvania Hospital and the following spring a bill was passed appropriating $15,000 for this purpose. He had also strongly advocated the establishment of free schools and this, too, came about. However, he failed to be reappointed one of the port physicians, a position he had enjoyed.

During the greatest calamity of this country, the yellow fever epidemic of 1793, Rush made one of his gravest mistakes, but did his most valiant work. While he fought the plague desperately, when numbers of the doctors left the city, "it is painful to add that his theories about the disease were less than half true, and that in his plan of treatment he was as wrong and as obstinate as he was brave."[1] His devotion to blood-letting and his claim that the disease was caused by putrefaction within the city itself brought him the heaviest condemnation he ever suffered.*

A commission appointed by the College of Physicians reported that the cause of the epidemic was the presence of sickness on three ships lying in the harbor. Rush, finding that some rotted coffee was lying on the wharf, rushed to the conclusion that the cause of the fever lay there. It had been the general opinion for years that poisonous miasmas arose from decomposing vegetable matter. For a half dozen years Rush tried to prove that he was right. The citizens were infuriated because they thought he was defaming the city. The seat of government was temporarily moved to Germantown and President Washington, at Mount Vernon at the time of the outbreak, avoided the city and took up his residence in Germantown.

During the epidemic Rush worked day and night, scarcely taking time to eat, often drinking milk and eating fruit at the patient's bedside, and visited more than 100 patients daily. He bled patient after patient in his own office until the bowls were overflowing. His sister who refused to leave him died. Within an hour he was again driving to see his patients. Five of his students got sick and three of them died. Twice he got the disease, once almost died. He bled himself as freely as he did his patients. Other physicians charged that his excess bleeding and purging caused many of the deaths. The fact remains that Rush treated thousands who lived.

The vigorous attack upon Rush by his fellow physicians had so aroused public opinion that it practically ruined his practice. He had a large family to rear and educate. He had refused in 1795 to become director of the United States mint at an annual

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This article on Benjamin Rush has been presented in two sections, the first of which appeared in the September issue of The Modern Hospital. It was prepared shortly before Dr. Ball's death last July.

* Rush was not the only one given to excessive bleeding, for the death of George Washington is laid to the treatment given by his physicians. This 69 year old man was bled repeatedly until within 13 hours he had been bled of 2½ quarts of blood. (Brickell, J.: Observations on the Medical Treatment of General Washington. Tr. Coll. Phys. Philadelphia **25**: 90, 1903.)

salary of $750, feeling he would be criticized as he had been in past years for his participation in public affairs. Moreover, his practice had been worth three times that amount. He had hoped to bring his son into his office, and besides, he was hoping to establish a new system of physic. When the office of treasurer of the mint became vacant in 1799, Rush obtained the office through President John Adams. It carried a salary of $1200. It was an easy post, which he held for the rest of his life.

ATTACKED BY COBBETT

His private practice further dwindled when newspaper attacks were launched against him by John Fenno, editor of the *Gazette of the United States* and William Cobbett in the *Porcupine Gazette,* in 1797. He was attacked for his "lunatic system" of medicine and he was charged with losing seven patients out of eight in the epidemic.

Rush sued Fenno for libel but dropped the suit inasmuch as he stood little chance of being convicted by his fellow citizens. Cobbett, however, went too far. He callied Rush a poisonous trans-Atlantic quack and a Samson of medicine who slaughtered thousands of citizens. With every good deed of Rush ignored, Cobbett claimed that the Israelite slew his thousands but the Rushites their tens of thousands. Rush sued for libel, and was awarded $5000 but settled for $4000, a sum he gave to charity. Cobbett was ruined and finally left the country.

A new, less severe epidemic of yellow fever came in 1798 and Rush devoted his time to charity patients. When the last of the epidemics came in 1802, Rush was 57 and full of good works. Despite "a long-time weakness in the chest," he was busy preparing lectures, pamphlets, scientific and philosophical books and preparing his book on diseases of the mind. In 40 years he taught more than 3000 students who were loud in their praise of his ability. He helped many financially through their student years. Goodman wrote: "It is upon his fame as a physician that Rush's immortality will rest. Excellently trained for his day, conscientious and skillful . . . his contributions both in theory and practice of medicine were invaluable and even today his descriptions of focal infection, cholera infantum and dengue are considered classics. His excursions into the almost virgin soil of psychiatry were remarkable for their originality and insight."[2]

Rush wrote in his Autobiography: "With all the folly and indiscretions of my life, with all the odium to which my opinions in medicine, politics and religion exposed me, and with all the pecuniary defalcations which have been mentioned, I believe I did more business, and with more profit, between the years 1769 and 1800 than any contemporary physician in Philadelphia. Thus it is, the providence of God often blesses men in spite of themselves, and finally protects them from the evils to which an adherence to the dictates of their judgments and well meant endeavors to promote knowledge and public happiness expose them."

More than a century after his death (1813), Robinson in 1929 wrote "The Myth of Benjamin Rush," attacking the writings of the long-honored physician. He wrote, "There are few medical writers, and certainly none of celebrity, whose works are less worthy of perusal today than those of Rush. The books of our forefathers often amaze us by their knowledge and insight, but Rush is equally surprising by his paucity of thought. Endless trivial but unverified anecdotes, dictatorial but incorrect assertions, a total absence of humor and eternal preaching and moralizing in inflated rhetoric —these are the characteristics of the voluminous writings which Rush has bequeathed to a posterity which honors his memory and does not read his books. . . . The history of medicine has no room for myths, and to say today that the work of Benjamin Rush belongs to the classics of medicine is to be guilty of myth-making. The ancient Hippocrates (460-370 B.C.) is modern; the 'modern' Rush (1745-1813 A.D.) is antiquated."[9]

Almost as venomous as the editorials of Cobbett of 1797, this attack is as unwarranted. Many of the writings of Rush are not scientifically true today after a century of discoveries in the medical field but his works ranked high in the literature of his day. His book on mental diseases, the first written in America, stood until 1883 as the only American textbook of that nature. Although Rush contributed much to the betterment of military hospitals during the Revolutionary period, his greatest contribution to hospitals was his plea for better, more scientific treatment of the insane that brought about separate departments and special hospitals for these patients. He protested against their cruel treatment in the hospitals, pointed out the dampness of their cells in winter, their heat in summer. He advocated therapeutic baths, occupational therapy, music, and a trained director over the mental department of hospitals. He indicated the relationship of insanity to bodily disease, to excessive drink, lack of nourishment and even to occupations. He suggested shock therapy by use of cold showers. He believed that often insanity is curable. Many of his therapeutic measures would be scorned today, now that psychiatry has come so far. But, most of all, Rush stressed kindness, gentleness, proper feeding and comfort for these much abused people. He noted the beneficial effect of malaria on the insane and suggested sending the insane to the New Jersey swamps to obtain a dose of malaria. It was many years later that fever therapy was first used.

"If men are to be judged severely because they are not ahead of their times, it might go hard with some of us here today. . . . What our successors one hundred years from now may say about us is at least an interesting subject for meditation."[4]

SON BECAME DESPONDENT

Rush's book on mental diseases has been called a masterpiece. It was written the year before he died. Certainly Rush knew of what he wrote, for he had visited the mental hospital of Pennsylvania for many years, long before his first-born, beloved son became a patient there. Dr. John Rush was in the navy in 1807 when he killed in a duel his commanding officer and best friend. A year later in a deep melancholia he was admitted to the hospital from which he had been graduated and where his father had served so long.

Benjamin Rush was a prolific writer. The best known among his published works are:

"An Enquiry into the Natural History of Medicine Among the Indians." 1774.

"An Account of the Bilious Remitting Yellow Fever as It Appeared in the City of Philadelphia, 1793." 1794.

"Medical Inquiries and Observations." 1789-1819.

"Essays, Literary, Moral and Philosophical." 1798.

"Introductory Lectures to Courses of Lectures Upon the Institutes and Practice of Medicine." 1811.

"Medical Inquiries and Observations

(*Continued on Page* 142)

About People

Administrators

Dr. Madison B. Brown, executive vice president and medical director of the Roosevelt Hospital, New York City,



Dr. M. B. Brown



Peter B. Terenzio

since January 1949, has resigned to accept the position of administrator, medical director, and executive vice president of Hahnemann Medical College and Hospital, Philadelphia. Prior to going to Roosevelt Hospital as its chief executive, Dr. Brown was assistant director at Johns Hopkins Hospital, Baltimore. He had been assistant director at Roosevelt Hospital before going to Johns Hopkins in 1941. During the war he was a lieutenant-colonel in the army medical corps. Succeeding him on November 1 at Roosevelt Hospital will be **Peter B. Terenzio,** director of Greenville General Hospital, Greenville, S.C. Mr. Terenzio had served as assistant director at Roosevelt for nearly three years before leaving in November 1952 for the position in Greenville. His administrative residency was served at Evanston Hospital, Evanston, Ill., and he received his master's degree in hospital administration from Northwestern University.

Naomi Bitz, administrative assistant, Orange Memorial Unit, the Hospital Center, Orange, N.J., has resigned to accept the position of administrator of Dobbs Ferry Hospital, Dobbs Ferry, N.Y., effective September 21. She completed her administrative residency at the Hospital Center, Orange, N.J., and earned a bachelor of science degree in nursing education and administration from New York University, New York City. In 1952 she received a master's degree in hospital administration at Yale University. She is a member of the American Hospital Association and the New Jersey Hospital Association, and a nominee of the American College of Hospital Administrators.



Naomi Bitz

William K. Klein has been named director of Long Island College Hospital, Brooklyn, N.Y., succeeding **Bernard McDermott,** who has retired. Mr. Klein, who takes over his new duties October 1, had been superintendent of the Hurley Hospital, Flint, Mich., for six years. Before serving at Hurley Hospital, he was assistant director of the University of Minnesota Hospital in Minneapolis. He is a director of the American College of Hospital Administrators and a member of the American Hospital Association.



William K. Klein

Paul D. Youngdahl has been appointed assistant administrator of the Methodist Hospital, Houston, Tex. Mr. Youngdahl is a graduate of the course in hospital administration at the University of Minnesota.



Paul D. Youngdahl

(*Continued on Page* 200)

Dr. Buerki Named Chairman of Modern Hospital Editorial Board

CHICAGO.—Dr. Robin C. Buerki, executive director of the Henry Ford Hospital, Detroit, has been appointed chairman of the editorial board of The MODERN HOSPITAL, Raymond P. Sloan, publisher, announced here last month. Dr. Buerki has been a member of the magazine's editorial board and an editorial adviser for a number of years. As chairman of the editorial board, he succeeds the late Dr. Arthur C. Bachmeyer, who was chairman for several years prior to his death.

A graduate of the University of Wisconsin and the University of Pennsylvania Medical School, Dr. Buerki served as professor of hospital administration and administrator of the State of Wisconsin General Hospital at Madison from 1923 to 1941, when he went to the University of Pennsylvania as director of hospitals and dean of the Graduate School of Medicine. In 1948, he became vice president of the university in charge of medical affairs. He moved to Detroit as executive director of the Henry Ford Hospital in 1951.

Throughout his career, Dr. Buerki has been active as a hospital consultant, teacher, lecturer and member of numerous study groups. He was director of study for the Commission on Graduate Education; he is a member of the Advisory Board for Medical Specialties, and has been a member of the Federal Hospital Council since it was organized in 1946. Dr. Buerki has been president of the American Hospital Association and of the American College of Hospital Administrators.

Richard D. Vanderwarker, director of Memorial Center for Cancer and Allied Diseases, New York City, has been named a member of The MODERN HOSPITAL's editorial board, in the division of administration, Mr. Sloan announced. Mr. Vanderwarker, who has been an editorial consultant to the magazine for the last three years, was formerly director of Passavant Memorial Hospital, Chicago.



Robin C. Buerki, M.D.

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ADMINISTRATION IS A HEALING ART

Employes may influence the patient's recovery, in this view, which makes the administrator responsible for the hospital's emotional tone

RICHARD N. KOHL, M.D.
Assistant Professor of Psychiatry
New York Hospital
New York

THE recovery of patients treated in a hospital is never solely dependent upon members of the medical staff but is also dependent upon the hospital environment as well as upon those who administer it. The modern hospital is not merely a building in which treatment is practiced, but is a special environment which is primarily a therapeutic agent in itself. It is the purpose of this article to describe some of the ways in which the course of every patient's illness is dynamically influenced by the hospital, by the hospital administrators, and by the policies for which they are responsible. These influences are far more significant than is generally accepted.

OPTIMUM CONDITIONS NEEDED

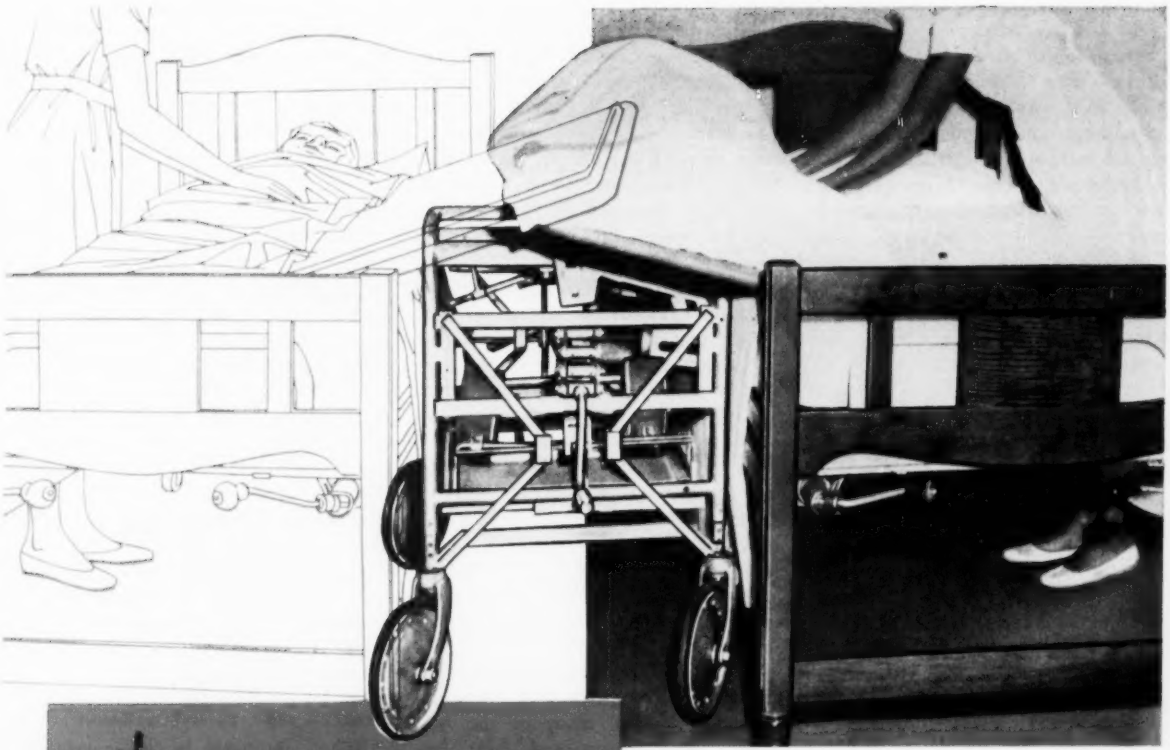
Thus far, studies dealing with the therapeutic aspects of hospital administration have come principally from those psychiatric institutions where patients are hospitalized over long periods of time and where environmental factors are most readily adapted to the individual needs of the patients. Therapeutic results have been found to be directly related to the hospital's ability to ensure for each patient the optimum conditions for recovery. Therefore, many psychiatrists regard hospital administration and treatment as inseparable.

A similar attitude may be applied profitably to the administration of general hospitals as well, and all department heads, whether physicians or not, may thus play a significant rôle in treatment. At the New York Hospital, psychiatrists are assigned as consultants to the various medical divisions of the general hospital and thereby come into frequent contact with all members of its staff. Advice regarding management of a mentally disturbed patient frequently applies as much to members of the administrative staff as it does to the physicians and nurses who are treating the patient. Lectures are also made available to volunteers, dietitians, department heads and others, so that many of the general principles of psychiatry may be utilized in their daily contact with patients.

Every patient is to some extent helpless and dependent upon others. When threatened by his illness, he becomes insecure and may be unable to cope with the demands of his environment. As a result of this insecurity, he has an increased need for love, affection, respect, understanding and even forgiveness. When the patient is unable to admit these needs to himself or to others, he may express them in the form of excessive demands, irritability, resentment or criticism. Such reactions are often directed toward the hospital employes rather than toward the physicians. Because a patient is more dependent upon his physician and thus fears rejection by him, he may vent his resentment originally felt for the physician on the administrator. When such a situation exists and is well tolerated by the administrator, it is not difficult to cope with unreasonable resentment. At the same time, the patient will be able to continue in a positive relationship with his therapist without conflict since the release of his resentment may relieve much of his anxiety. The ability to tolerate and accept a patient's resentment may be one of the major factors which contributes to the patient's recovery. Numerous studies have shown that headaches, gastric pain, skin rashes, increased blood pressure, and other symptoms are directly related to unrecognized or unexpressed resentment.

UNDERSTAND ALL ASPECTS

The satisfaction of a patient's needs depends upon an understanding of his illness in all of its aspects. A passive or submissive patient who readily accepts the state of dependency which his illness forces upon him may remain placid in spite of the severity of his symptoms. However, lack of fear does not necessarily indicate courage. Enforced dependency may give rise to hostility, resentment, and irritability in the aggressive patient who is accustomed to being independent and competitive. Both resentment and depression may accompany an illness particularly in those patients who previously had little concern for their state of health. Depression is often associated with guilt which may be derived from the patient's inability to attend to his responsibilities. Depres-



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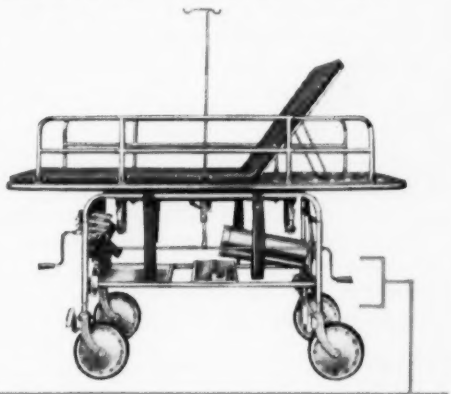
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sion may also arise from the patient's feeling of dependency.

Some degree of resentment is always present in a dependent person and, since he is dependent, he is afraid to express resentment which may then be turned back upon himself in the form of depression. The patient characterized by body overconcern may initially welcome his illness as a means of justification for his many previous complaints. However, as the illness progresses, he usually becomes increasingly concerned and seeks endless reassurance from all those about him. The maid as well as the physician may be called upon to satisfy this excessive or insatiable need for reassurance.

Modern medicine is concerned with a sick individual rather than with a sick organ or part of that individual. We no longer refer to the patient in terms of his disease only, but regard him as a person with emotional as well as physical needs. Objective observation and management of the behavior which he displays within the setting of the hospital will contribute a great deal to the total evaluation of his illness. We cannot expect a part of him to be well unless we attempt to treat him as a total personality. The prolongation, intensification or alleviation of a patient's emotional distress will depend to a considerable extent upon the administrator's ability to deal with the patient objectively. Objectivity depends upon awareness of those factors which dynamically influence the patient's reaction to the hospital as well as to his illness. Such dynamic factors are the age of the patient, the nature of his illness, his family constellation, his economic status, his responsibilities, his intelligence, and his personality in general.

CHILDREN HAVE SPECIAL PROBLEMS

A child may be an ideal patient only because he may not comprehend the seriousness of his illness and may be unaware of its possible complications. However, he may misinterpret his symptoms and, since he is more dependent upon his parents, he may be less tolerant of separation from them. Enforced separation from relatives may give rise to considerable anxiety. At the same time, separation from relatives may be essential to the patient's recovery. The treatment of a number of patients, both children and adults, may be seriously handicapped unless contact with visitors can be curtailed. The physician may then rely heavily upon a receptionist's ability to cope with the anxiety of those persons whose visiting privileges are restricted. If this task were left entirely to the physician, he would have little or no time to treat the patient. The receptionist will be better able to cope with the many demands of the anxious relatives when he is aware of the relationship between them and the patient. It is a common experience for a hospital employe to change his attitude from one of resentment to acceptance when he learns of the many factors which give rise to the unreasonable demands of both patients and their relatives.

A 16 year old male was admitted to the hospital for treatment of a gastro-intestinal disorder which had resisted all forms of medical treatment. During his stay in the hospital, it became increasingly apparent that the patient's mother was a major obstacle to his recovery. Each of her visits was followed by an exacerbation of symptoms. Although this was not generally known, many of the hospital administrators and their employes were irritated and annoyed by the numerous demands and criticisms of this mother. Not until these reports reached the physician in charge were active steps taken to stop all visits. This could not be accomplished until the patient was transferred to the psychiatric division where the mother was literally locked out in order to protect the patient. In many respects, the mother was sicker than the patient and only when all those who were in contact with her were informed of the nature of her exaggerated concern was the physician able to control the patient's symptoms and eventually discharge him as recovered. The therapeutic result in this case was largely dependent upon the various administrators and their employes who were able to deal with this situation objectively. One could hardly have expected the patient to cope with his anxious, demanding mother if all those less personally involved were unable to control their own personal feelings in the situation.

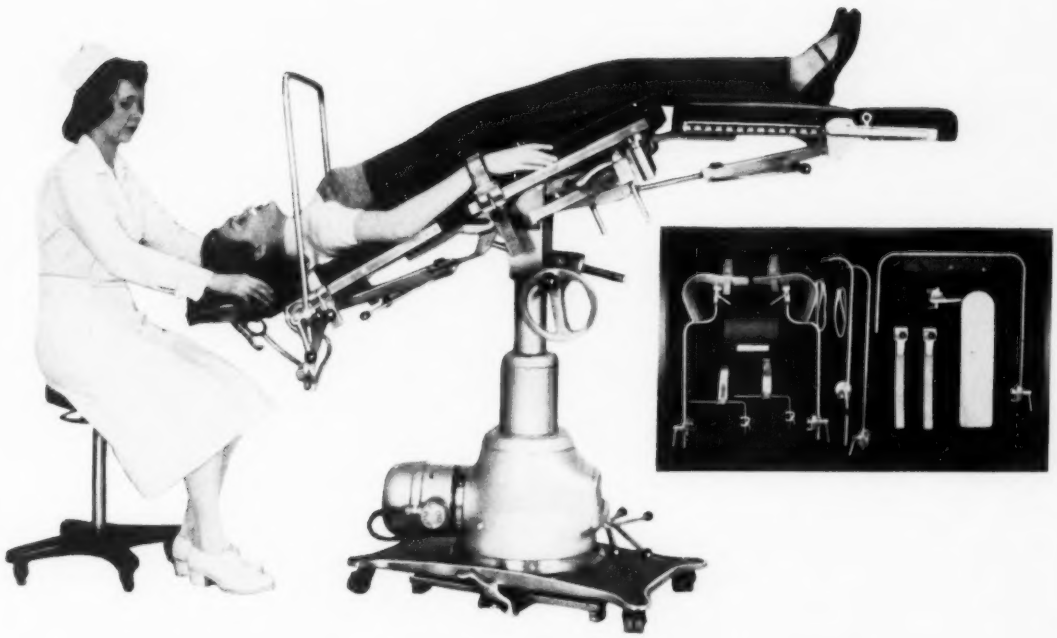
An adult patient may be more realistic than a child but may be less tolerant of his illness because of responsibilities which it forces him to relinquish. When concerned about members of his family and the status of his job, he may react by various forms of emotional distress which may be projected onto his environment. He may become overly sensitive to any form of authority and consequently may be uncooperative with regard to the rules of the hospital. He may even assert his individuality to the extent that it interferes with his treatment.

On the other hand, an illness may become an opportunity to give up responsibility and to receive the attention that the patient does not ordinarily receive. Such a reaction may result in prolonged convalescence or in failure to respond to the usually successful forms of treatment. We do not want the hospital to become a haven for those who cannot adjust themselves to reality. Therefore, we may do the patient an injustice when we attempt to satisfy all of his demands. In such cases, it is essential to help the patient to develop independence in every possible way. He must recover from his illness emotionally as well as physically.

REALITY MAY BE INTOLERABLE

When an illness is closely related to lack of love and attention, efforts made to satisfy all of the patient's needs may prolong his illness, since he can hardly be expected to want to get well when being well implies a return to intolerable reality. Such reactions are frequent when existence within the hospital is more pleasurable than it is on the outside. Thus, private nurses may be contraindicated since they may only intensify the patient's need for attention. Special privileges may permit the patient to continue the expression of his symptoms and thus prolong his illness. Management of this kind must be individually determined and should be based upon an understanding of the patient as a total personality.

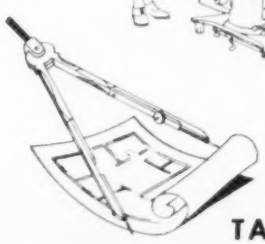
When an illness is gradual in onset, a patient has more time to adjust himself to its consequences and is therefore less acutely threatened by it. An illness with an acute onset may bring about an overwhelming state of anxiety which in turn seriously interferes with his adjustment to the threatening situation. Anxiety may then be expressed in the form of defiance, apathy, ideas of persecution, irrational fears, and other pathological symptoms. These symptoms are often first demonstrated in the admissions office and their management at this point may determine the patient's re-



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action to all future treatment. If a suspicious patient is poorly managed at the time of admission, he may become distrustful of all those who are responsible for his care during the ensuing course of his illness. Such distrust can seriously interfere with his progress and may develop into a psychiatric illness characterized by fixed, false beliefs of a persecutory nature.

A middle aged man, while being treated for an acute abdominal disorder, developed a mental illness, characterized by the belief that members of the hospital staff were attempting to poison him. This reaction appeared to be unreasonable until it was learned that an attendant had carelessly remarked to a nurse in the patient's presence that he was exaggerating his symptoms. The patient was a proud man who felt that his illness might incapacitate him and prevent him from fulfilling his ambitions as a successful business man. His anxiety was so great that he was unable to tolerate criticism and consequently accused others of misjudging him and eventually of attempting to destroy him.

WATCH THOSE COMMENTS

The attendant was assigned to another ward and only after the patient's abdominal disorder had subsided was he able to trust those who were responsible for his care. When well, he was no longer anxious and was able to discuss and understand the nature of his acute psychopathological reaction. Careless comments, teasing, joking and even laughing in the presence of sensitive patients may give rise to similar psychiatric disorders.

A patient's anxiety and consequently his symptoms may be increased when a relative regards management of the patient as inadequate or in error. Such a reaction on the part of the relative is often due to his own personal experience. For example, if he has had difficulty in parking his car, he will arrive in the patient's room feeling resentful and may express this resentment in the form of criticism of the patient's care. The attendant who deals with visitors in the parking area thus may unknowingly influence the course of the patient's illness.

The high cost of medical care may have a marked influence on the emotional state of the patient. When financially limited, the patient may suspect that he is not receiving the best of care. In order to avoid this



particular fear, he may complain about all therapeutic procedures, as well as the food, nursing care, and laboratory tests. A female patient may experience less anxiety as a result of her illness than does a male patient since he is more likely to be financially responsible for others. Most male patients cannot afford expensive and prolonged care when they are not working and therefore must be treated at the expense of charitable institutions. A patient who is financially dependent upon the hospital may be resentful owing to pride or to the need for regarding himself as an independent individual. The cashier may be the one who bears the full force of this resentment, particularly when treatment has not been successful. Such a patient may question unreasonably the validity of his bill and may even accuse the accounting department of errors and neglect. When an error has been committed, a dissatisfied patient may seize upon this as the justifiable object for the resentment which has accumulated during the course of his illness.

DELAYS MAKE PATIENTS RESTLESS

Employes in the record room may contribute indirectly to the comfort or discomfort of a patient. Prolonged delays in making charts available to the physicians working in the outpatient departments of the hospital will often account for a patient's restlessness, irritability and resentment, which in turn may increase the severity of his symptoms. The physician's ability to deal efficiently with the patient will also depend upon the prompt availability of those records which are essential to a thorough understanding of the case.

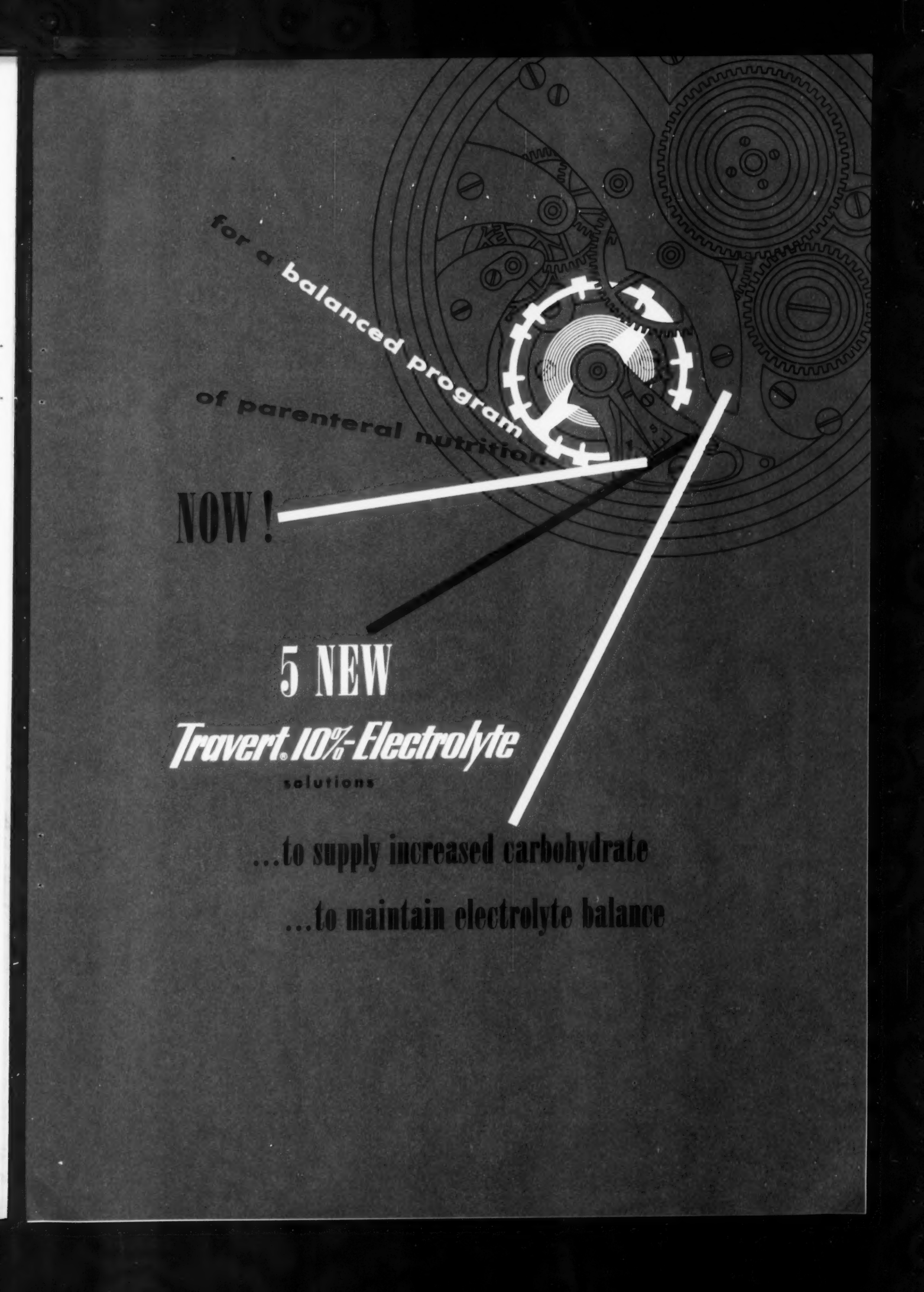
Since a patient's feeling of security in treatment depends to some extent upon the reputation of the hospital, those who are responsible for its public relations will play a therapeutic rôle. Information concerning significant medical experiences, the treatment of individual patients, and the management of accidents may have a negative or positive effect upon the patient's attitude toward his medical care. The trust and confidence of a patient are often important contributory factors to his recovery.

Members of the hospital's volunteer department not only act as aides to other departments but also contribute services which are independently significant in treatment. Numerous talents and skills have been made available to patients through the use of volunteers. Not only have they been able to assume many of the burdens of the professional staff but they have also been able to satisfy many personal needs which formerly were neglected in the treatment of the patient as a total personality. Volunteers who can act as a source of entertainment have played an increasingly important rôle in the treatment of chronically ill patients who are confined to the hospital for long periods of time. Interpreters may also play a significant rôle in treatment since awareness of therapeutic procedures is essential to cooperation and to the general security of the patient. These are only a few examples of the many services which are derived from the volunteer department.

DIETITIAN IS TARGET

Dietitians frequently are the recipients of unreasonable criticism and resentment from both patients and hospital personnel. When ill, a patient may require a special diet and at the same time may regard food as his only pleasure. Because such needs are often incompatible, resentment originally directed toward the physician may be projected onto the dietitian. Inasmuch as eating is one of the principal sources of pleasure and relaxation for members of the house staff, they too may project their irritability onto the dietitians when the food is not to their liking. A physician's ability to deal with his patients successfully throughout the remainder of the day may, to some extent, depend upon his satisfaction or dissatisfaction with the food which is available to him.

The physical nature of the hospital will in itself dynamically influence the course of the patient's illness. The quality of the hospital's appearance and its maintenance will go far to establish an initial positive or negative attitude toward treatment. Therefore, those persons responsible for plant op-


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. . . to supply electrolytes and correct mild acidosis



Travert-Electrolyte No. 2 500 CC. AND 1000 CC. CONTAINERS

(Na 57.0 mEq/liter, K 25.0 mEq, Cl 50.0 mEq, Lactate 25.0 mEq, Mg 6.0 mEq, HPO_4 12.5 mEq, Travert 10%)

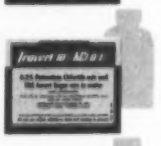
. . . to furnish electrolytes when neither acidosis nor alkalosis is a problem



Travert-Electrolyte No. 3 1000 CC. CONTAINERS

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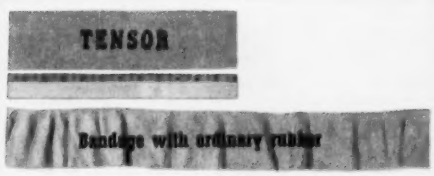
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erations may play an important therapeutic rôle. It would be difficult to deny that the architecture, the well kept appearance, and the efficient management of a hospital have considerable effect upon every patient who is admitted for treatment. Decoration is also of therapeutic significance because everyone reacts emotionally to the appearance of his surroundings.

This aspect of therapy was most clearly demonstrated by the comments of a well known decorator. When called upon to decorate a hospital, she admitted herself as a patient and, among other things, found that the ceiling was of considerable importance to her comfort. This was particularly true in her case as the ceiling was marked by a jagged crack and was lighted by a crooked chandelier. Much is yet to be learned with regard to the use of color as it affects treatment of the patient. However, the relationship between color and mood has gained increasing importance and there has been a widespread trend away from the traditional use of white in hospital decoration.

JOBS OFFER SECURITY

It is not unusual for a patient to ask a floor clerk about the opportunities for a job in the hospital. The employment manager is summoned and steps are taken to investigate the availability of work which is suitable to the patient's needs and abilities. Whether or not a job is obtained, the consideration given to the patient will act as an impetus to recovery and contribute to his feeling of future security. The desire to recover from an illness is often impeded by the realities which accompany a state of good health.

Most hospital administrators are aware of the many complaints which are related to unnecessary noise in the hospital setting. These complaints are often justifiable since most patients are more or less anxious and, owing to this state, are more sensitive to noise. Both anxiety and noise interfere with sleep which is particularly important to those patients who are uncomfortable or in pain. Even laughter may increase the anxiety of a patient who is proud, sensitive and suspicious as he may interpret such behavior as being directed toward him.

An immature or poorly organized personality may react to minor frustrations and incapacities by severe psychological upheavals while the mature, well organized personality may adjust to extreme anxiety with little or no psychological deviation. A patient's intelligence and previous hospital experience will also determine to what extent it is necessary to explain the meaning of therapeutic and administrative procedures in order to relieve his anxiety.

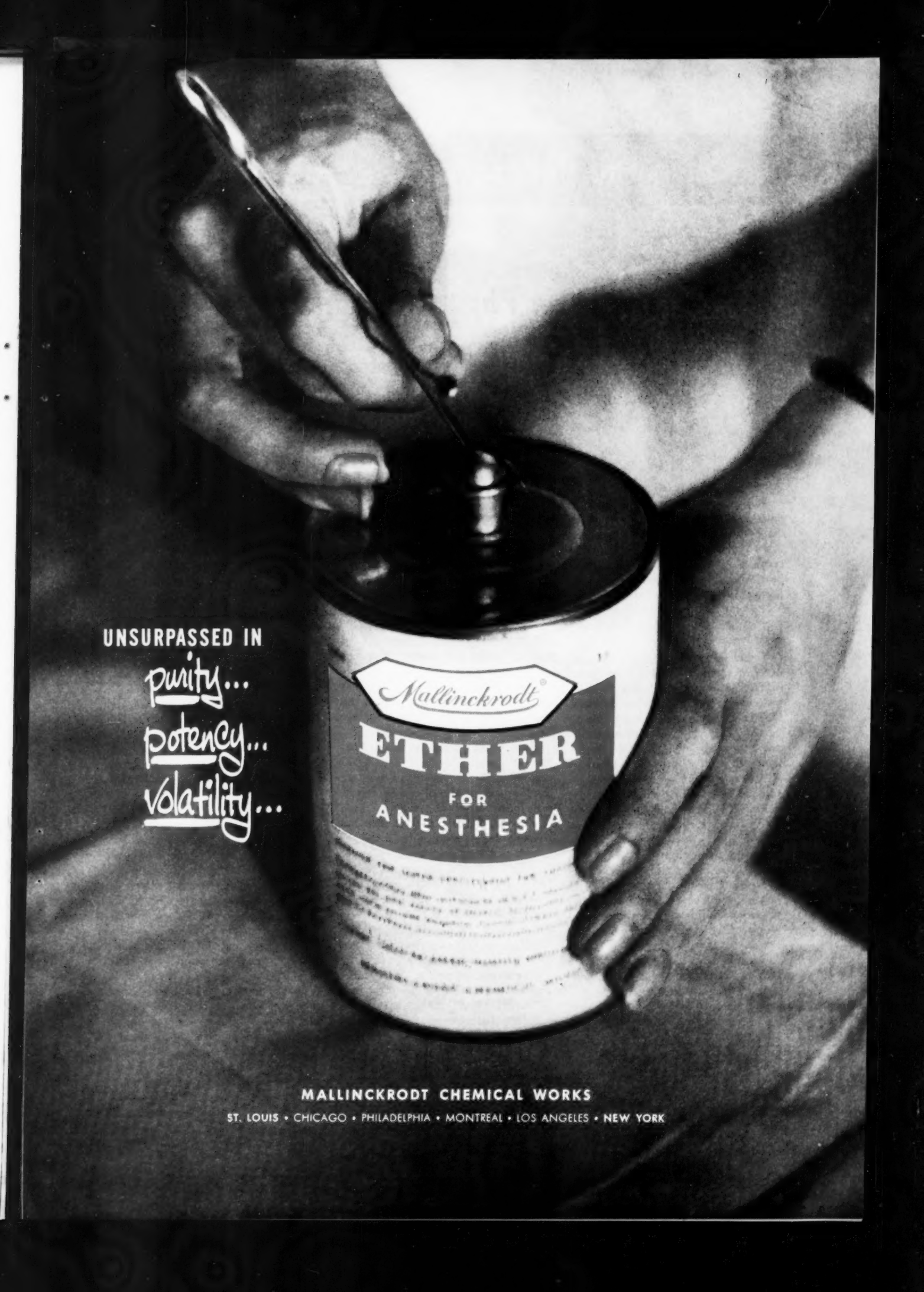
An obstetrical patient who had recently come from a foreign country and who was of limited intelligence presented a language difficulty and was unfamiliar with the environment of a modern hospital. These factors contributed to her insecurity and eventually to the development of an acute panic reaction. There was no evidence for a toxic, infectious or metabolic disorder that might account for her disturbed state. During delivery, she expressed the wish to die, became excited and was uncooperative. Upon return to the ward, she immediately requested to see her child and, when this request was denied, she became suspicious and refused to remain in bed. Owing to her excitement, her child was removed from her care and confined to the nursery. Medications were prescribed to check the secretion of milk. As a result, she believed that her baby had died. Medications, given hypodermically for the purpose of controlling the panic, were interpreted as attempts to kill her. This disturbed state increased in intensity until a volunteer worker acted as an interpreter. When the patient was able to comprehend the therapeutic management of her case, she quickly recovered and was able to leave the hospital.

Among the many mental reactions seen in a general hospital, a delirium perhaps requires the most efficient teamwork on the part of personnel. A delirious patient may be uncooperative to various examinations and therapeutic procedures owing to impairment of his comprehension, attention span and memory. Therefore, it is usually necessary to repeat frequently the meaning of his medical management. When disoriented, he becomes increasingly confused by changes in his environment. Treatment and contact with the patient should be confined to as few individuals as possible. When possible all therapeutic procedures should be performed by one nurse and one physician. Visitors must be restricted to those individuals who can contribute to the patient's feeling of security. Inasmuch as fear and extreme emotional lability are marked, he is easily frightened and suicide is an ever present danger. All objects which may be a source of danger to the patient should be removed from his room and windows must be made secure. An uninformed housekeeper, a laboratory technician, or a nurse's aide may accidentally overlook or leave behind an object which the patient might later use to injure himself. The patient's room should remain lighted so that darkness and shadows do not add to his fearful state. He should be treated in a quiet area and in one where he can be easily observed by the nurses. The ward location of the patient is also significant inasmuch as discussions between patients may be a source of anxiety and fear. Therefore, the floor nurse's awareness of the interpersonal relationships on the ward is of dynamic significance in the management of her patients.

ALL GROUPS ARE AFFECTED

The ability to deal objectively with an emotionally disturbed patient is not only dependent upon an understanding of the patient's reaction to his illness but is also dependent upon one's understanding of himself. It is the patient's privilege to expect to be managed by individuals who are themselves mature and experienced in dealing with sick people. Therefore, it is essential that all those who come into contact with both patients and their relatives be aware of the origin and nature of their individual reactions. A patient's racial, religious, economic and social status may account for quite different attitudes on the part of those who are responsible for the patient's care. Treatment of the patient will also be influenced by the interpersonal relationships among administrators, physicians, nurses, dietitians, social workers, and others. Therefore, the mental health of the individual as well as of the group as a whole is significant in the total management of every patient.

All hospital employes may in some way dynamically influence a patient's recovery or failure to recover. When such a concept of medical care is generally adopted, not only will the patient profit from his hospital experience but each employe will be able to regard himself as responsible in some way for the outcome of the patient's illness. No employe should overlook or neglect the therapeutic aspects of his job, however menial or remote from the patient's care it may seem to be.


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New Trends in Physical Medicine

have changed our approach to chronic illness

FRANK H. KRUSEN, M.D.

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Head of the Section of Physical Medicine and Rehabilitation
Mayo Clinic, Rochester, Minn.

PHYSICAL medicine and rehabilitation as a special branch of medical practice is rapidly growing in importance and its development should receive the attention of everyone concerned with modern developments in hospital practice. Several trends have been noted which have led to remarkable changes in our approach to the care of patients who are chronically ill or seriously disabled.

Trend 1. Increase in the amount of chronic illness and serious disability. Because we have learned to prevent death from many acute illnesses, we are prolonging the lives of many people until finally some chronic illness develops. Also because of the increased tempo of modern living, a greater number of serious injuries are sustained on the highway, in industry, on the farm, or in the home. Improved medical and surgical procedures now save the lives of seriously injured persons who previously would have died. But although lives are prolonged by prevention of death from acute illnesses or serious injuries, the number of persons having chronic illnesses and serious disabilities is ever on the increase.

An appalling number of American citizens suffer from some chronic disease or injury which will require a new type of medical care and hospital management. Ivy has estimated that the number of handicapped persons in the United States in June 1950 included 4,000,000 adults and 750,000 minors having orthopedic handicaps, 2,000,000 adults and 750,000 minors having deafness, 180,000 adults and 67,000 minors having blindness, 500,000 adults and 300,000 minors having epilepsy, 3,500,000 adults and 500,000 minors having cardiac disease, and 2,500,000 adults and 3,500,000 minors having speech disorders. Thus Ivy has estimated that a total of 12,680,000 adults and 5,867,000 minors in the United States suffer from these six handicapping conditions alone.

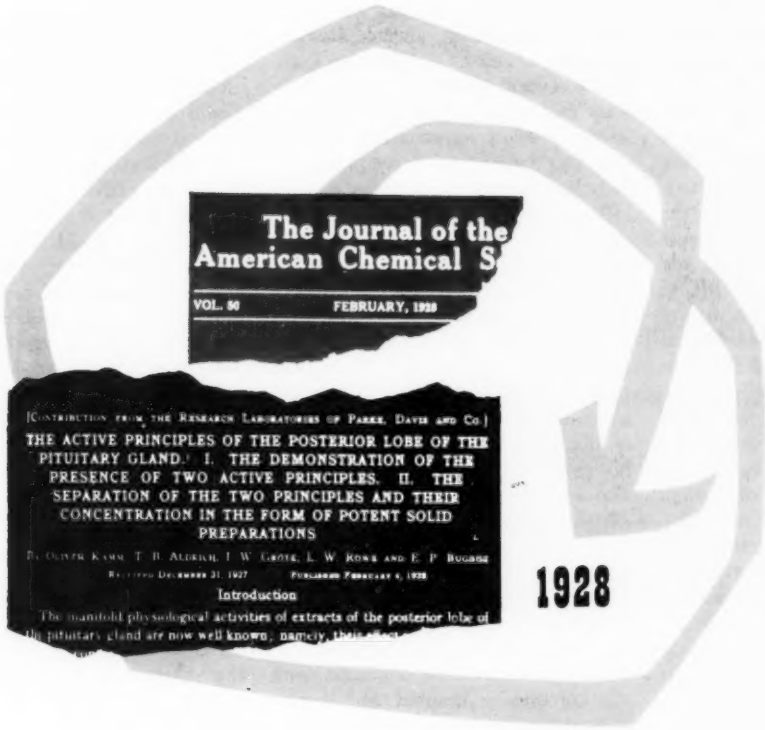
Furthermore, it has been estimated that altogether there are 23,000,000 persons in the United States who are handicapped because of disease, injury, maladjustment or war wounds. Each year about 250,000 American men and women are so disabled by injury or disease that they become incapable of holding a job or of enjoying a normal life. Surveys have indicated that at least one and a half million of the many millions of disabled persons in this country (not including veterans disabled in service) would benefit greatly from rehabilitation services.

The number of civilian casualties far exceeds the number of war casualties. Whereas some 265,000 men were permanently disabled as a result of combat injuries during World War II, 1,250,000 civilians were permanently disabled, by accidents alone, in the corresponding four years. A high percentage of these disabled persons are so severely handicapped that the process of rehabilitation, to be effective, must include a combination of many services. Simultaneously, medical, social, psychologic, vocational and other services must be provided in order for these persons to achieve their maximal usefulness in society.

Trend 2. Changing emphasis in medical practice from preoccupation with the diagnosis and treatment of specific acute diseases to consideration of the over-all management of the patient having chronic illness or serious injury. Up until 1900, medical practitioners and hospital organizers devoted their major attention to the causes, diagnosis and cure of disease. Efforts in this direction have been outstandingly successful so that we have extended the life span of the average individual from 49 years in 1900 to approximately 70 years today. Extraordinary progress has been made since 1900 in reducing mortality in our country. A number of infectious diseases, such as typhoid fever and the principal communicable diseases of childhood, have been all but wiped out as causes of death. The death rate from tuberculosis has been cut by about 90 per cent since 1900 and the record for pneumonia is almost as impressive.

By this process of postponing death, we have, however, established the need for a whole new set of community responsibilities and hospital practices. We must now labor to make longer

From a paper presented before the general session of the Upper Midwest Hospital Conference, St. Paul.



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life bearable for all seriously disabled persons. We have saved many chronically ill and seriously injured persons from death but there can be worse things than death. It may be much more humane to save such a person from years of dependency than to save his life. We must now develop new hospital facilities to rehabilitate the chronically ill and disabled because we must learn now not only to add years to life but also to add life to years. Modern hospital practice of physical medicine and rehabilitation is beginning to fill this need but there is much yet to be done.

To understand this trend, we should be familiar with certain definitions.

Physical medicine and rehabilitation includes the employment of various physical agents and devices, therapeutic exercises, corrective procedures, occupational therapy and physical rehabilitation in the management of disease and injury.

Occupational therapy may be defined as medically prescribed activity which has a therapeutic objective.

Rehabilitation has recently been defined as "the restoration through personal health services of handicapped individuals to the fullest physical, mental, social and economic usefulness of which they are capable, including ordinary treatment and treatment in special rehabilitation centers."

In the new book, "Community Planning for Human Services," based on a study made in St. Paul, Bradley Buell and his associates state that: "Acceptance by the community of some measure of responsibility for the protection of its members against the consequences of illness dates far back in historical times. Traditionally, the focus of this concern has been upon measures to prevent and cure specific diseases. The philosophy that health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity' is of more recent origin, and is only beginning to be translated into practical community programs."

The Baruch Committee on Physical Medicine and Rehabilitation, in reporting on the organization of an ideal community rehabilitation service and center, remarked: "Rehabilitation service and rehabilitation centers are community projects, and all of the existing facilities and organizations in the community must be fully utilized. The rehabilitation center must be a part of the community rather than a thing within it. . . . It must be a program of integration, and duplication should be avoided. . . . Existing facilities and local conditions are the primary factors in governing the organization." Many communities are now working toward the development of this third trend.

Trend 3. Toward the development of coordinated local community projects (preferably in close affiliation with the community hospital) for the rehabilitation of persons who are chronically ill or seriously disabled. In developing community projects for the rehabilitation of persons who are chronically ill or seriously disabled, it is essential that they be restored not only physically but also mentally, socially and vocationally to the best possible life compatible with their abilities and disabilities.

To achieve such rehabilitation, the Baruch committee has suggested the following plan: A rehabilitation center or project should be organized that must operate in close affiliation with the community hospital and should, if possible, be in close juxtaposition to the hospital. In the ideal community rehabilitation unit, patients would be derived from a number of sources. A traveling field clinic could provide rehabilitation service in rural areas, and this field clinic could send certain patients to the rehabilitation center. Patients could also be referred by the physician, by self-reference, and by social and governmental agencies, industry, labor and the civilian hospitals.

The center itself should be divided into an evaluation and program placement service and a service in which actual rehabilitation is accomplished. The former would be divided into three sections: one for medical evaluation, one for psychosocial evaluation, and one for vocational testing and evaluation. Consultants from the center would provide a rehabilitation consultation service for the community hospital and also provide hospitalized patients with "in-bed" rehabilitation programs.

After the disabled person had been properly evaluated, he would proceed to the treatment program where he would receive physical rehabilitation, psychosocial readjustment, and prevocational and vocational training. The physical medicine program would include physical therapy, occupational therapy, and physical retraining; in the psychosocial program actual treatment and adjustment would be provided, and in the vocational education program there would be prevocational and vocational retraining and special education projects. Finally, there should be a laboratory for research in physical medicine and rehabilitation and also there should be a dormitory of the domiciliary type for housing patients unable to travel.

Thus there would be an active and living program that would tend to combat any tendency toward chronic invalidism. All patients would be guided toward self-sufficiency and independence. The more fortunate would be returned to full employment, those with limited disabilities would be returned to selective employment, still more seriously handicapped persons would be provided with the opportunity for self-support through the medium of the sheltered workshop, and the extremely handicapped persons would be provided at least with a home-bound program of activities that would help toward making them self-sufficient. Likewise, in connection with such a center, there should be provided a service for outpatient guidance and follow-up.

This is the ideal center as conceived by the Baruch committee and modifications of it can be considered and developed with proper effort in any community.

Trend 4. Growing interest in physical medicine and rehabilitation on the part of the medical profession. For more than a quarter of a century, the American Medical Association has had a council which devoted its attention to certain phases of physical medicine and rehabilitation; originally called the Council on Physical Therapy, for the past several years it has been called the Council on Physical Medicine and Rehabilitation and has expanded its interests accordingly.

In 1947 the Advisory Board for Medical Specialties established the American Board of Physical Medicine and Rehabilitation to qualify physicians in this new medical specialty, and finally in 1949 the American Medical Association established a regular Section on Physical Medicine and Rehabilitation. Thus this new special field of medical practice has been established permanently as an integral part of general medical practice.

Trend 5. Growing interest in teaching of physical medicine and rehabilitation in medical schools and

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teaching hospitals. Only a decade ago, less than half a dozen medical schools provided adequate programs of teaching in physical medicine and rehabilitation. Today, however, at least 45 of the 72 medical schools of the United States provide some instruction in the subject. Thirty-three schools report that they have already appointed one or more qualified specialists in physical medicine and rehabilitation to their faculties. Likewise 20 additional medical schools, which now do not have fully organized programs in physical medicine and rehabilitation, have expressed an interest in the early establishment of such programs.

Only a decade ago, there were just five residencies in physical medicine available at three institutions. Today there are 87 approved residencies in physical medicine and rehabilitation available at 43 different teaching hospitals. The training of ancillary personnel (physical therapists and occupational therapists) to work in hospital centers of physical medicine and rehabilitation has increased rapidly. Today there are 31 approved schools of physical therapy and 24 approved schools of occupational therapy in existence, and 15 additional medical schools have now agreed to establish new courses for physical therapists and 14 medical schools have agreed to establish new courses in occupational therapy.

Despite this great increase in training facilities for medical specialists, physical therapists and occupational therapists, the national growth of physical medicine and rehabilitation has been so rapid that the demand for such personnel continues to exceed greatly the supply.

Trend 6. Development of research in physical medicine and rehabilitation. Real advances in any program for the care of the sick and disabled can be made only through a triple approach in which efforts to provide service, education and research are combined. Research is the basis for all the advances that will come in the fields of service and education. Clinical research during World War II led to the recognition of the importance of physical medicine and rehabilitation in the care of our wounded soldiers and sailors. Amazing new developments in the rehabilitation of amputees came from clinical researches in the navy and striking new methods for rehabilitation of paraplegics came from the army.

These war-time clinical investigations have revolutionized rehabilitation methods in civilian institutions. War-time research also has completely revolutionized the methods of convalescent care for many types of disabled persons who were formerly permitted to lie hopelessly in bed but who are now being trained to become self-supporting, self-respecting citizens.

It has been estimated that approximately 97 per cent of all handicapped persons can be rehabilitated to a point at which they can obtain gainful employment. The final result of continued clinical research in this field may be a tremendous increase in the amount of health, happiness, opportunity and productivity of our disabled citizens.

In addition to the growth of clinical research, there is growing interest in laboratory research in physical medicine and rehabilitation. New physical agents and new devices are being discovered which will aid the handicapped person toward more rapid recovery. The constant development of new devices and procedures in physical medicine and rehabilitation is essential for continued progress.

Trend 7. Increasing number of well organized departments of physical medicine and rehabilitation in hospitals. More and more hospitals are now developing truly well organized departments of physical medicine and rehabilitation. In order to function properly, such departments should be under the direction of a physician especially trained in this field of medical practice, and the ancillary personnel who assist this physician should have been trained in approved schools of physical therapy and occupational therapy.

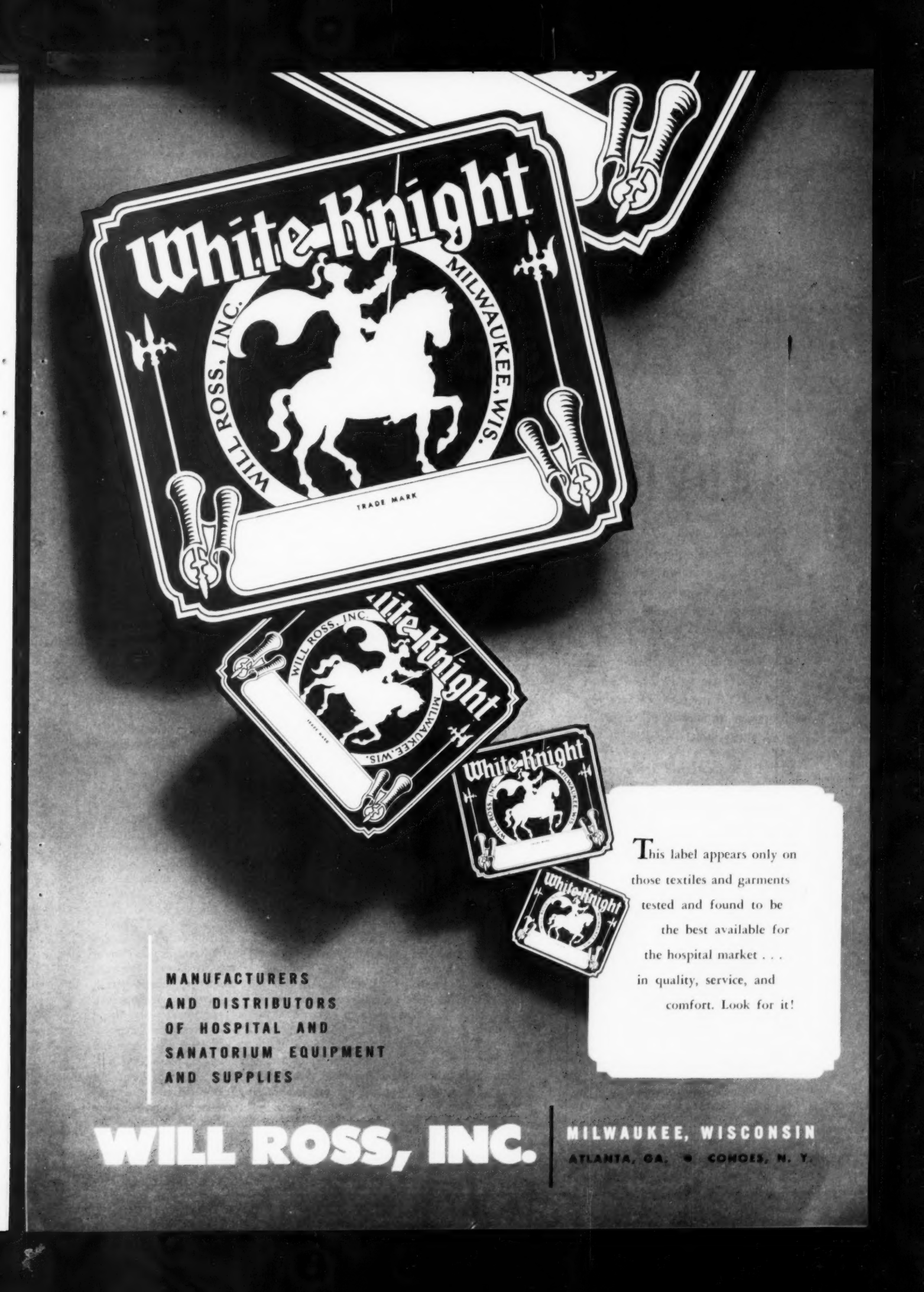
In the well organized hospital department of physical medicine and rehabilitation, the medical specialist directs the activities of the therapists in much the same way that the medical specialist in roentgenology directs the activities of the x-ray technicians or that the medical specialist in clinical pathology directs the activities of the laboratory technicians. He serves as a consultant to the referring physician. He sees the disabled patient and prescribes in detail the treatment or diagnostic procedure to be followed. Then the therapist applies under his direction certain physical therapeutic or rehabilitative procedures which will aid in restoring the disabled person to more nearly normal activity.

A wide variety of therapeutic and diagnostic procedures is employed to restore the patient to physical recovery. Both physical therapy and occupational therapy are utilized to achieve this end. Psychiatric and psychologic methods are used when necessary to achieve proper motivation and correct mental adjustment. Recreational programs are frequently included in the plan for rehabilitation of the patients. Prevocational and vocational training may be necessary, and finally vocational placement may be required in order to get the disabled patient back to productive citizenship, happiness and self-respect. The physicians working in a well organized program in a hospital department of physical medicine and rehabilitation will finally develop various projects in research and in teaching.

It has been said that the adequate program for evaluation, guidance, training and reestablishment of disabled persons would include the following steps toward full rehabilitation: (1) registration, (2) medical diagnosis, (3) vocational diagnosis and guidance, (4) rehabilitation planning, (5) social welfare, (6) treatment, (7) training, (8) selective placement, (9) recreation and (10) follow-up.

When a department of physical medicine and rehabilitation has been established at a medical center for a few years, it can contribute toward the hastening of the recovery of a fairly high percentage of all patients (not only the chronically ill but also the acutely ill) who come to that medical center. For example, the section of physical medicine and rehabilitation at the Mayo Clinic which has been in existence for 16 years treated, during 1951, 11.5 per cent of all the patients who visited the clinic.

Trend 8. Increase in the development of large institutes of physical medicine and rehabilitation in affiliation with community hospitals. More and more communities are building large institutes of physical medicine and rehabilitation which are affiliated with community hospitals or medical centers. In New York City there is affiliated with the Presbyterian Hospital, Columbia Medical Center, the famous Institute for the Crippled and Disabled. Also in New York City in affiliation with the Bellevue Hospital, New York University Medical Center, there has recently been constructed a magnificent new Insti-



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tute of Physical Medicine and Rehabilitation.

In Peoria, Ill., a new Institute of Physical Medicine and Rehabilitation has recently been built as a unit of the St. Francis Hospital, and a similar institute as a unit of the Methodist Hospital in Peoria is now nearing completion. In Cleveland, the Cleveland Institute of Rehabilitation is affiliated with the Cleveland City Hospital and Western Reserve University School of Medicine. The huge new National Institutes of Health in Bethesda, Md., has its own physical medicine and rehabilitation unit incorporated with the institute buildings and occupying certain floors of the new National Institutes.

At the University of Minnesota in Minneapolis two floors of the new Mayo Memorial Medical Building have been set aside to house the expanding department of physical medicine and rehabilitation. At our own Mayo Clinic in Rochester, new enlarged departments are being planned for the clinic building and for inclusion in a new wing at St. Marys Hospital. These are a few examples. Other similar institutes are springing up all over the country. Most of them tend to follow the plan and suggestions laid down originally by the Baruch Committee on Physical Medicine and Rehabilitation.

Trend 9. Trend toward giving the chronically handicapped person his "place in the sun." Modern hospital organizations are laboring valiantly at last to bring the chronically handicapped person out of the back bedroom or the "home for incurables" and into productive activity and happy citizenship. Rusk and Taylor in their book, "New Hope for the Handicapped," tell the following story concerning a young woman who finally found her place in the sun. They wrote: "Recently in one of the large midwestern cities, a severely disabled young woman came to the local state employment service to consult its selective placement specialists concerning a job. Thirty-six years old, she had never been employed. When asked by the placement specialists why she had not come in to see them before, she replied that for 19 years she had not been out of her home.

"Paralyzed after an accident while a senior in high school, she had spent most of her time in bed. Through correspondence with another shut-in, she had learned of a modern rehabilitation clinic where braces were fitted and crutch walking taught. Five months after she was carried into the clinic, she was able to walk with crutches into the employment service to seek work.

"There is a tragedy in the 19 wasted years of this young woman's life, but the real tragedy is that her story is not unusual. It is duplicated in the majority of communities in this country, with the exception that few such stories have a happy ending."

If our hospital administrators will make serious efforts to develop good departments of physical medicine and rehabilitation, we should have many more happy endings to such stories and many fewer "shut-ins."

Mary E. Switzer, the director of the federal Office of Vocational Rehabilitation, has pointed out that people are not rehabilitated, they are only given an opportunity to rehabilitate themselves. Rehabilitation is a bridge spanning the gap between uselessness and usefulness, between hopelessness and hopefulness, between despair and happiness.

Even some of our keenest observers have not fully understood the implications of modern rehabilitation and then have suddenly come to the realization of how the disabled are now being trained to find their "place in the sun." For example, in 1948 David Hinshaw wrote: "For years I had closely followed the work of the Institute for the Crippled and Disabled in New York City, and yet I had missed the emergence through it of the miracle of the composite science of rehabilitation. Suddenly I realized that its staff was using medicine and surgery, psychology and psychiatry, therapy, patience, kindness, friendly understanding, and vocational training in their efforts to help the physically handicapped reeducate themselves to live and work and love by enlisting their minds, hearts and bodies."

Bernard Baruch has said: "The investment in rehabilitation is an investment in the greatest and most valuable of our possessions, the conservation of human resources." If all of us will endeavor to develop such conservation programs by organizing well coordinated departments of physical medicine and rehabilitation in our own community hospitals, we will be repaid in enormous dividends of health, happiness, opportunity and productivity in the community, the state and the nation.



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Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

5-Hydroxytryptamine (Serotonin: Enteramine)

HISTORY

IT HAS been known for many years that the serum of various animals contains a substance or substances with vasoconstrictor properties (1869 Ludwig and Schmidt, 1906 Meyer). In 1912 O'Connor was able to show that this substance was not adrenalin, and confirmed the observations of Stevens and Lee (1884) that the active substance was formed in the process of clotting. In 1918, Janeway, Richardson and Park provided evidence that a smooth muscle stimulating substance (or substances) in serum was formed from platelets. Serum prepared from plasma which had been centrifuged to free it from nearly all its platelets was found to possess little or no vasoconstricting activity or muscle stimulating activity (Ried, Bich, Rand, Janeway, Richardson, and Park). These and subsequent investigations led to the conclusion that the foregoing substance (or substances) existed already preformed in platelets and that its liberation was incidental to the clotting process. Accordingly it became possible to prepare platelet extracts from platelet-rich plasma which could be activated by mechanical shaking.

A series of reports by Erspamer and co-authors presents evidence of a similar smooth muscle stimulating substance found in extracts of rabbit stomach and intestinal mucosa, in extracts of the skin of various amphibians, and in extracts of the posterior salivary glands of the Octopodes (a squid-like animal) and of the hypobranchial body of the Muricidae (amphibia native to the coast of Italy). By means of histochemical, paper chromatography, and ultraviolet absorption spectrum technics, this substance was found to be the specific secretion or storage product of the enterochromaffin cell system found in various glandular organs of both vertebrates and invertebrates. The substance was therefore appropriately named "Enteramine."

In 1948 Rapport *et al.* isolated from beef serum a crystalline vasoconstrictor substance having the structure, 5-hydroxy-3-beta-aminoethylindole (5-hydroxytryptamine) as a creatinine sulfate complex containing one mole of water of crystallization. It was given the name "Serotonin." Further investigations resulted in the synthesis of this material by three independent groups of investigators (Rapport *et al.*; Hamlin and Fischer, Speeter *et al.*). Later Erspamer isolated and identified 5-OH-tryptamine as the picrate salt from extracts of the posterior salivary glands of Octopus vulgaris and of the skin of Discoglossus pictus. This, therefore, proved Erspamer's "Enteramine" and the serum vasoconstrictor agent designated by various other authors as "Serotonin," "Vasotonin," "Spätgift," and "Thrombocytin" to be identical compounds with wide distribution in the various organs of vertebrates and invertebrates.

CHEMISTRY

(according to Speeter *et al.*)

The full chemical name of the synthetic product is 5-hydroxytryptamine creatinine sulfate monohydrate (structure shown in Figure 1).

The compound melts at a temperature of 214-215° C., and has a molecular weight of 405.36; it is very slightly soluble in alcohol, acetone, and other common organic solvents. Two to 3 per cent solutions may be prepared at 50° C., but the compound will crystallize on cooling to room temperature.

The material is stable as a crystalline solid but undergoes gradual decomposition in solution. It is suggested that solutions be kept refrigerated and used within 24 hours of preparation. Alkaline solutions accelerate the decomposition of 5-hydroxytryptamine.

ANTIMETABOLITES AND INACTIVATION

Thus far the most effective antimetabolite antagonizing the various effects of 5-OH-tryptamine seems to be another indole compound, 2-methyl-

Fig. 2: Structure of 2-methyl-3-ethyl-5-aminoindole.

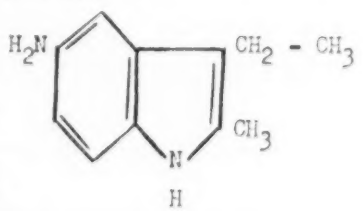
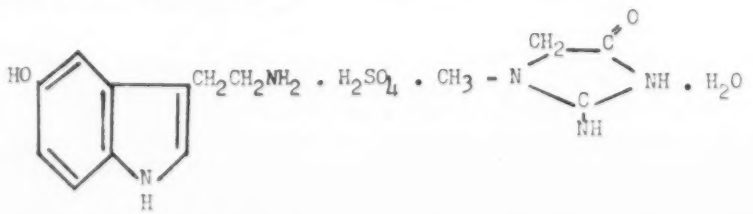


Fig. 1: Structure of 5-hydroxytryptamine creatinine sulfate monohydrate.





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3-ethyl-5-aminoindole, the structure of which is shown in Figure 2. Note the similarity of this structure to that of 5-OH-tryptamine.

Treatment of 5-OH-tryptamine with certain oxidizing and halogenating agents such as potassium persulfate, potassium permanganate, and iodine in high dilutions causes its inactivation. Deamination, benzoylation, formol treatment, and ultraviolet irridiation also reduced the activity of Enteramine extracts studied by Erspamer. According to this author, an alkaline pH increased the activity of the extracts whereas an acid pH decreased its activity.

TOXICITY

Toxicity studies by Speeter gave the following results:

Acute LD/50 in mice (I.V.)—367 mg/kg.

Acute LD/50 in rats (I.V.)—69 mg/kg.

Acute subcutaneous LD/50 in rats —greater than 2000 mg/kg. The principal toxic symptoms displayed were sporadic crawling movements. Respiration was depressed and there were signs of irritation manifested by intense biting and scratching of areas in the posterior regions (Rapport and Virno).

PHARMACOLOGY—GENERAL

5-OH-tryptamine has generally been found to cause a contraction of all types of smooth muscle with the exception of coronary smooth muscle. Evidence of increased coronary blood flow with this compound tends to substantiate this. The compound produces spasmogenic activity on the isolated rabbit, rat, mouse and guinea pig gut. In intact, anesthetized dogs and rabbits, intravenous doses as low as 20 ug. cause marked intermittent spasms and blanching of the intestine. Previous atropinization does not alter these responses. Similar responses were observed with atropinized, isolated mouse, rat, and guinea pig uteri. On the nonpregnant guinea pig uterus the drug was found to be about 1/40 as active as ergonovine maleate (Freyberger). According to Erspamer the rat oestrus uterus is the most sensitive test object for the qualitative demonstration and quantitative estimation of 5-OH-tryptamine. The dog and cat urinary bladder responds to injections of 5-OH-tryptamine with muscular twitchings and evacuation.

The drug causes constriction of isolated arterial strips, and when administered to the intact animal intra-arterially, the response is always constrictor. A constrictor effect is observed in the femoral vein *in vitro*, and a dilator effect is seen *in vivo*.

In chloralosed cats bronchoconstriction and pulmonary vasoconstriction followed by an increase in pulmonary arterial and right ventricular pressure is seen following rapid intravenous injection of 0.5 ug/kg.

Cardiac effects of the drug in the cat are those of bradycardia apparently mediated by reflexes carried in the vagal nerves since the bradycardia is abolished by vagotomy, procaine or atropinization, but is still present following carotid sinus denervation.

Comroe *et al.* have noted reflex cardio-pulmonary changes in cats including bradycardia, hypotension and apnea in addition to the bronchoconstriction and increased pulmonary arterial pressure already mentioned. By means of localization studies this group was able to locate these reflexes as arising in part from receptors in the circulatory bed between the right auricle and aortic valves, and in part from receptors in the distribution of the coronary arteries or of vessels in the ascending aorta. Adequate evidence was presented that the hypotension was due to the bradycardia since it (the hypotension) can be antagonized by atropinization and vagotomy, and the blood pressure response can be reversed by blocking the autonomic ganglia with TEA (Page), pentamethonium, or pendiomide (Schneider and Yonkman). The apnea, however, usually persists in spite of atropinization and ganglionic blockade. Schneider and Yonkman have shown an increase in the frequency of action potentials of inspiratory active vagal fibers in the cat when 5-OH-tryptamine is injected intravenously. This increase in frequency is caused by stimulation of stretch receptors and presents direct evidence for the action of 5-OH-tryptamine on sensory vagal nerve endings in the cat lung. This respiratory arrest can be abolished by local anesthesia of peripheral vagal nerve endings.

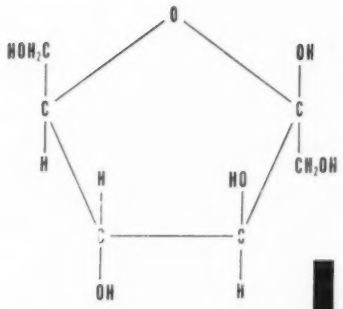
In dogs, however, as shown by Heymans and Van Den Heuvel Heymans, the response is somewhat different, 5-OH-tryptamine producing a primary rise of blood pressure with bradycardia, followed by a secondary tachycardia and a marked hyperpnea. Again the bradycardia was shown to be a reflex action due to a primary increase in systemic arterial pressure, but instead of apnea as in the cat, hyperpnea occurred consistently in the dog. These authors were able to find no difference in the circulatory and respiratory effects following section of vagi-aortic and carotid sinus nerves, but they are in disagreement with Douglas and Toh who were able to reduce or abolish the hyperpnea and circulatory effects after denervation of the carotid sinuses and section of the vagi-aortic nerves. The latter authors claim 5-OH-tryptamine to be respiratory stimulant in the dog, such stimulation being produced by several mechanisms among which are stimulation of vagi-aortic and carotid sinus afferent pathways. Obviously, more work is needed on this phase of the drug's action.

5-OH-tryptamine has been shown to act directly on the cells of the adrenal medulla to cause the liberation of epinephrine. However, the rise in blood pressure seen following injection of 5-OH-tryptamine in dogs occurs even following bilateral adrenalectomy (Ried), proving this action to be at least partially owing to the drug's direct vasoconstrictor action (such action has been demonstrated on hind limb, intestine and kidney of the dog).

BLOOD PRESSURE

The blood pressure responses to 5-OH-tryptamine have been erratic in character depending on dosage, route of administration, the condition of the circulatory system, and the animal species used. Intravenous administration produces changes in blood pressure which may be pressor, depressor or biphasic in character. These responses are not significantly altered by atropinization but usually enhanced by such ganglionic blocking agents as TEA. Speaking generally, according to reports thus far presented, the response is usually pressor in dogs (Freyberger) and human beings (Spies and Stone), depressor or biphasic in cats, and depressor in rats. The blood pressure response to 5-OH-tryptamine is the result of actions at several loci, among which may be some of the following:

1. Factors tending to cause an increase in blood pressure:
   (a) Direct vasoconstriction, except for coronaries
   (b) Central sympathetic stimulation
   (c) Increased cardiac output—(venoconstriction)
   (d) Intestinal spasm
   (e) Epinephrine release



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2. Factors tending to lower blood pressure
   (a) Vasodilation in the muscle bed
   (b) Buffer nerve activity
   (c) Central sympathetic depression
   (d) Cardiac depression
   (e) Pulmonary vasoconstriction
   (f) Vagal stimulation

PHARMACOLOGY—KIDNEY

Renal studies by Erspamer and Ottolenghi have shown 5-OH-tryptamine to possess an antidiuretic action in rats. Using the picrate salt in subcutaneous doses of 0.2 to 2.0 mg/kg. these authors noticed in rats a reduction in glomerular filtration rate by 50 to 80 per cent, and a less marked reduction in renal plasma flow. There was also a concomitant reduction in urine volume during the first hour following the administration of the drug. Since the hypotensive effect of the drug at these doses was negligible, and since little or no increase in ureteral or pelvic pressure could be ascribed to the drug, the authors postulated that such reduced urine output accompanied by a fall in glomerular filtration rate must be the result of augmentation of afferent renal resistance owing to a tonus increase or spasm of the contractile structures in the afferent glomerular bed of the rat. Some increase in tubular reabsorption was also noted, but this can probably be more simply explained by the prolonged contact with the tubular epithelium of the reduced quantity and flow of the filtrate rather than to a direct stimulating action on tubular reabsorption itself. Doses greater than 2 mg/kg., however, also produced a hypotensive effect, so that the antidiuretic action of 5-OH-tryptamine at such doses is the result of the lowered systemic blood pressure as well as the renal vasoconstriction.

It was furthermore found that the antidiuretic response in rats was only roughly proportional to the dose of the picrate salt, *i.e.* 0.3, 1.0, 2.0 mg/kg. provoked nearly the same responses in intensity and duration. It is believed, therefore, that when maximum constriction of the afferent glomerular bed is reached, little or no further constriction can be achieved by larger doses of the drug. Nor can the vascular spasm be prolonged by larger doses because it has been shown that the enzymatic inactivation rates of not widely different quantities of 5-OH-tryptamine are practically the same.

More recent studies with dogs (Sala and Castegnaro), however, tend to minimize the rôle of 5-OH-tryptamine in afferent glomerular bed constriction and to emphasize its rôle in stimulating tubular reabsorptive activity. It follows, then, that the mechanism of the antidiuretic action of 5-OH-tryptamine may vary according to animal species and other conditions.

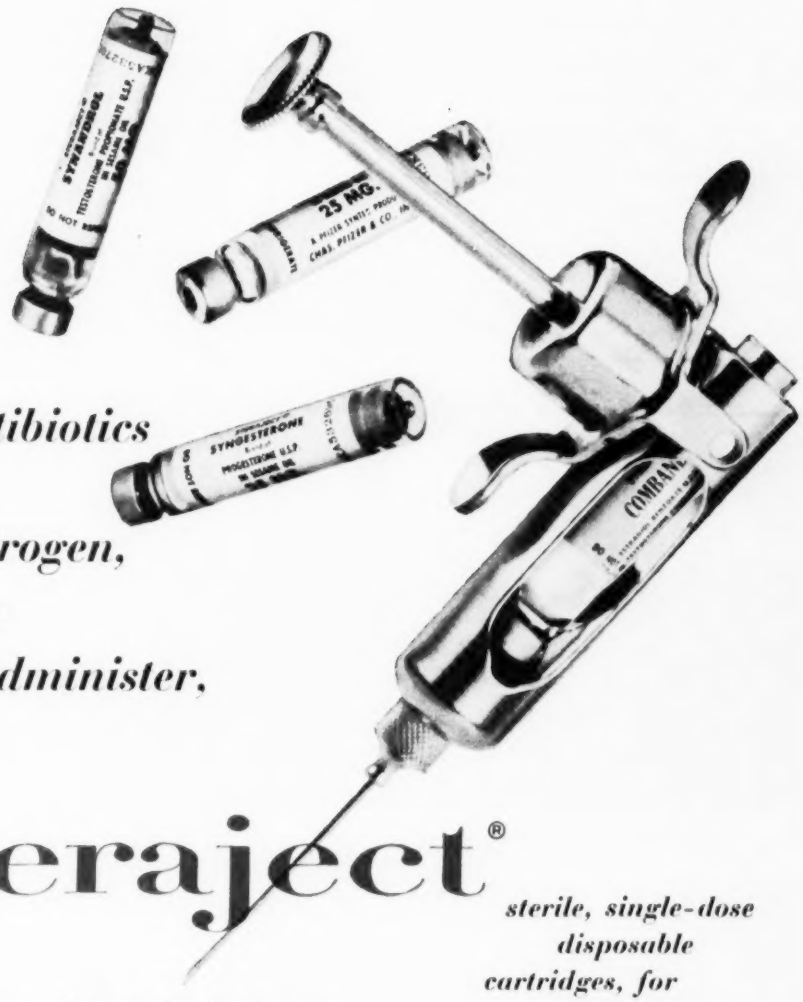
METABOLIC EFFECTS

Metabolic studies by Rapport and Virno on the rat reveal that 5-OH-tryptamine causes a marked depression in oxygen consumption of 20 to 60 per cent and lasting 20 minutes to 1 hour or longer with intraperitoneal doses of 0.5 to 8 mg/kg. of the creatinine sulfate monohydrate complex. Using rat liver mitochondria, studies by Hurwitz and Bain on the effect of 5-OH-tryptamine on oxidative phosphorylation indicate approximately 50 per cent uncoupling by the drug in concentration of 5×10^{-4} moles. In comparison, DNP at this concentration would give complete uncoupling whereas penothal would give 75 per cent uncoupling. Appreciable drops in body temperature have been observed in a few rats, but evidence of such general hypothermic action is inconclusive as yet.

SPECIFICITY

The various actions of 5-OH-tryptamine are mimicked to some degree by other indolalkyl amines, such as tryptamine and 5 methoxy tryptamine. The fact that excesses of tryptamine desensitize the gut to itself and to 5-OH-tryptamine and vice versa (Gaddum) suggests that these two compounds act on the same receptors. These receptors are not muscarine receptors since the actions of these two compounds are not blocked by atropine. This also distinguishes 5-OH-tryptamine from the active substance "P" (also found in intestinal extracts), and which is not desensitized by excesses of 5-OH-tryptamine. These facts suggest that 5-OH-tryptamine is only the type substance of a whole series of highly interesting compounds — the indol and the hydroxy indolalkylamines.

Studies by Erspamer on the inactivation of Enteramine extracts by animal tissues would tend to implicate an aminoxidase as the inactivating enzyme responsible, but conclusive evidence is lacking. Histaminase was not effective in inactivating the extracts. (*Continued on Page* 114)



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ANTAGONISTS

Futher studies by this same author on the effect of sympathomimetic and sympatholytic drugs on the physiological and pharmacological effects of Enteramine (5-OH-tryptamine) indicate that sympathomimetic drugs such as epinephrine reduce the antidiuretic action of Enteramine by increasing systemic blood pressure and intraglomerular hydrostatic pressure.

Some sympatholytic drugs, however, seemed to possess true anti-Enteramine properties, very probably blocking by competition the union of Enteramine with receptors of smooth muscles just as they do with epinephrine. The most effective drugs are the hydrogenated ergot alkaloids, such as dihydroergotamine and the beta halo alkylamine—dibenamine. Piperoxan, prosympal, 2924 RP, and priscoline were without anti-Enteramine action worthy of note. These investigations were carried out on rats. Freyberger found that dibenamine, in the cat, and SY-28, in the dog, provoked a decrease but not a blockade of the hypertension that was induced by 5-OH-tryptamine.

Reports by many authors on the influence of various antihistaminic agents on the actions of 5-OH-tryptamine have been, for the most part, brief and in several instances conflicting. A more recent report by Erspamer throws a little more light on the subject. This author found that several antihistamines possessed an inhibiting effect on the antidiuretic and oxytocic effects of 5-OH-tryptamine. Of the various drugs tested, pyribenzamine was most active, followed by phenergan, benadryl, neohetramine, thenylene, and antistin in this order. The enteraminolytic action of these antihistamine agents as a whole was found to be inferior in many respects to the sympatholytic drugs mentioned (dibenamine, dihydroergotamine), and showed no relation to their specific histaminolytic effects or their possible effects on the autonomic nervous system or on smooth muscle. The mechanism of this action is of course still left open to question.

POSSIBLE RÔLES

With all of the literature amassed on 5-OH-tryptamine there has been much speculation as to the possible physiological, pharmacological or pathological rôle of the substance. Following are some of the suggestions made by various authors:

1. Hypertensive principle (Page)
2. Specific hormone of the enterochromaffin cell system regulating renal blood flow (Erspamer)
3. Stimulation of glandular secretory activity (Feldberg and Toh)
4. Hemostasis — vasoconstriction (Brun, Rapport, Correll, etc.)
5. Pain mediator (Armstrong)
6. Cause of meconium embolus shock (Schneider)
7. Metabolism regulator (Correll, Rapport)
8. Tryptophane cycle (Undenfriend)
   (a) Hydroxylated in liver
   (b) Decarboxylated in kidney to form 5-OH-tryptamine
9. Possible rôle in pathogenesis of pulmonary embolus and coronary thrombosis (Comroe *et al.*)
10. Possible rôle in the pathogenesis of the "ischemic episode" in acute renal failure of toxic or nontoxic origin; possible rôle in the liberation of renin and the genesis of malignant nephrosclerosis and of renal hypertension, etc. (Erspamer).—ANGELO J. SPINAZZOLA, B.S., and THEODORE R. SHERROD, Ph.D., M.D.


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American Dietetic Association Report

Grace Bulman Named New President

MARY P. HUDDLESON

THOSE who once have visited the sunlit state of California usually hold it in fond memory, hoping to return. And so it was with the American Dietetic Association, returning to Los Angeles after 14 years. The old guard, recalling the shining days of late August 1939, found little outward change. The weather in August 1953 gave a repeat performance and the setting, amid the modernistic grandeur of the city's new Hotel Statler, almost compensated for the remembered elegance of the Ambassador.

THEY DID A GOOD JOB

An uneasy peace had ended in late August 1939, and the dietitian, true to her devotion to her job and her country, began to gird herself for her responsibilities to the nation's armed forces and its civilian and military hospitals. That she succeeded was well attested in August 1953. From a somewhat nondescript status in 1939, ranking army and air force dietitians were now proudly wearing their eagles while their sisters in nonmilitary hospitals were carrying on, apparently undeterred by the food and employe shortages they had undergone during the war years and the incoming and outgoing political and administrative changes since.

It was with considerable pride, therefore, that the association installed its 30th president, Grace Bulman, dietetic division chief of the Veterans Administration's department of medicine and surgery, Washington, D. C.

Unlike 1939, now there were dietitians and prospective dietitians from Okinawa, from Pakistan, Burma and Thailand, from far-off South Africa and near-by (overnight) Hawaii, from neighboring Canada, down-under Australia and other areas in the British commonwealth. The American Hospital Association sent its past president, Dr. Anthony J. J. Rourke, and its new president, Ritz Heerman; the American Medical Association sent Dr. James R. Wilson of the Council on Foods and Nutrition; the American Public Health Association was represented by Dr. William L. Halverson. Dr. Malcolm T. MacEachern, leading authority in the hospital administrative field and devoted advocate of the dietetic profession since its founding in 1917, honored the association by his presence at the "History of the Association" breakfast.

Perhaps the most striking contrast with the meeting 14 years ago was seen in the 29 radio and television performances by members of the association, several of which were on national networks. Hospital dietitians and dietitian-professors in medical schools, dignified dietitian doctors of philosophy and dietitian members of health and welfare departments of great insurance companies and of state and federal governments gave freely of their time to the newsman and the networks commentator.

Food and fatness fascinates the glamour circles in Los Angeles perhaps more than elsewhere, and Dr. Margaret A. Ohlson of Michigan State College, authority on the subject of overweight, rose to the occasion. The great corn-producing states of the Midwest, said she, also produce the highest incidence of adult human obesity in America. From her assured position as associate professor in the School of Public Health, University of Michigan, Adelia M. Beeuwkes discussed the characteristics of the "self-styled scientists who peddle panaceas to a gullible public." They sell or advertise directly, by-passing the medical profession completely; they promise to prevent or cure a number of diseases, and encourage self-diagnosis and treatment; if selling a diet supplement or special purpose food, they state or imply that our agricultural methods are undermining the health of the nation and our food processing destroys all food value.

EMPHASIS ON HOSPITALS

These and other topics of general interest to all dietitians were discussed: food technology, personnel management, the teaching of the nurse, the medical and dental student, and the dietetic intern, and nutrition research, to mention but a few. Yet the general impression carried away was that of greater emphasis on the interests of the administrative hospital dietitian and that of other managers of large group food services.

Some critics have felt that the American Dietetic Association, since its founding predominantly an organization of hospital dietitians, has at times disregarded the interests of the majority. A warning note in this connection was sounded by Mrs. Katherine M. Johnson, a former president, from her background of experience in the internal affairs of the organization, her many years as chief dietitian at Michael Reese Hospital, Chicago, and in hospitals in China and India. She urged us not to forget that hospital

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dietitians are "the backbone of the American Dietetic Association . . . the interest of the alert hospital dietitian are neither limited nor narrow . . . she is an important member of the hospital superintendent's administrative cabinet. Through the feeding of all patients she is allied with the interests of the medical and nursing staff. She participates in the scientific and economic research that is a part of the hospital's natural activity . . . by the teaching of student nurses, patients, dietetic and medical interns she takes part in the educational progress of the hospital."

TURNING THE CLOCK BACK

Among hospital dietitians who head the administrative work of the dietary department we have those who hold professorial rank on the faculty of medical and dental colleges. Some carry the title of assistant superintendent as well as chief dietitian. Yet there are hospitals which have recently replaced dietitians with hotel food administrators. "This," said Mrs. Johnson, "is turning history back 25 years. It is a difficult situation to understand. When a hotel man is employed in a hospital, a dietitian must also be employed. The use of two persons for what should be one job brings divided responsibility, twilight zones of responsibility, and sets up a weakened organization fabric."

Continuing her thesis, Mrs. Johnson asserted that in the early days when patients were on "special diets" or house diets such a division of authority might have appeared plausible. But for 25 years it has been well recognized that nutrition is a significant factor in the convalescence and recovery of all patients. "Since the importance of the normal diet has been emphasized so long in progressive hospitals, it seems strange that any reputable hospital would consider placing the food of the patients under the supervision of a person untrained in nutrition and allied science."

Some inkling of the way this comes about, the supersalesmanship of which dietitians, many physicians, and even hospital superintendents may be too little aware, could be detected in the address of Fred Schmidt of Fred Schmidt Associates, Los Angeles. There is a trend, said he, on the part of companies now operating industrial food services to enter the hospital and university field on a similar "fee basis." As a selling point these companies offer "an accumulation of facts, figures, and talent resulting from operating a multiple number of food facilities in various sections of the country." In the opinion of Mr. Schmidt, their top management group is prepared to recognize the latent possibilities that may exist for increasing volume, improving standards, or reducing operating costs. Further (and this may be the nub of the whole situation), they have the courage to recommend capital expenditures, to forecast the benefits as a result, and to present their recommendations to the administrator or board of directors in *a manner that makes official decisions easy.*

In my opinion it is in this respect—good salesmanship—that the methods of these companies surpass those of the dietitian. With the profit motive in mind, as successful businessmen they are able to "present "facts and figures" concisely and convincingly, aided in some instances by the technical skills of the dietitian and her intimate knowledge of the policies of her institution. (It was reported that five of the 6903 hospitals in this country have installed concessionaires. Elsewhere in informal discussion another informant commented that in England, where "catering systems" largely controlled hospital food services, the trend now appears to be back to the dietitian, when and if, of course, they can get her.)

In summation Mr. Schmidt said to his large audience of dietitians: "I see no reason why, as individual administrators of your food departments, you can't take the same approach that an outsider would in approaching your problems. Administrators and boards are willing to spend money for the things the public can see, but are disinclined to spend it in kitchens . . . where direct savings and improved service might result from better facilities." We repeat, it takes salesmanship to make them see the light. As Mr. Schmidt added: "A manufacturer first develops his product, then his manufacturing process, and then he goes into his sales promotion program."

At the same session one dietitian who knows her "buymanship"—Clarice Gullickson, chief, administration section, dietetic division, Veterans Administration, Washington, told "how to be right before you buy." It appears that while the chinaware industry continues searching for a mysterious ingredient that will make china bounce instead of break, the rest of the tableware industry has been busy setting an attractive table. New translucent opal glasses come in a variety of colors. New glass dishes have a high surface luster that does not crack or chip, decorations durable enough to withstand strong detergents and even steam sterilization; and toughened by a special process, they resist blows and heat shock.

Molded plastic dishes too have been showing their potentialities for high fashion table setting at low cost. The material does not break or chip, can be molded in any color of the rainbow, is light in weight (hence reduces fatigue of patient and worker) and delicate in appearance, has a very hard surface, is odorless and tasteless. In fact, Miss Gullickson added "plastic is almost too durable for its own good." Since the dishes do not break or chip the user refuses to replace those with stained or scratched surfaces. Even this will not happen for a long time, say the manufacturers, if hypochlorite bleaches are avoided and lightly chlorinated dishwashing compounds or the oxygen releasing type of stain remover is used instead.

Several hospitals in this country now use paper for food service exclusively. New plastic coatings make these dishes serviceable for hot and cold foods and there is a size and shape for every use. Quite at home on the hospital tray, their lightness is another asset.

CHINA IS BEING IMPROVED

The chinaware industry too is perfecting its product. The vitrified ware is now rugged and tough, and withstands continuous blows without excessive breakage. But if you must knock china about, use wood, rubber or plastic, since these are softer than the china. "Use plastic coated dish racks," warns Miss Gullickson, "and drainboards covered with rubber matting or wood." The glaze on china makes it still the easiest to clean, and it is the only type of tableware harder than the steel cutlery which attacks it three times daily. The hitch is that one piece of china will scratch another when two clean pieces are rubbed together in stacking. The speaker's final admonition was that convenient, inexpensive replacements are imperative when we think of the toll exacted by the reckless or hurried hands of employes at dishwashing time. *(Continued on Page 120)*

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Model 6230 Peeler
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10 Models, from 5 to 140 qts.



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Leading off from the standpoint of administrative interest was the address of Ella M. Eck, chief dietitian, University of Chicago Clinics. Discussing the finding and elimination of "hidden operation costs" Miss Eck said that these occur in neglected areas of food operation, owing perhaps to lack of training of the operator, lack of sufficient personnel to cover all areas adequately, or lack of alertness on the part of the operator and her supervisors. Good training and good practice of that training directed to all angles of the operation will prevent hidden costs.

Miss Eck listed the main items of food operation expense in this order: equipment, labor, food and supplies. From the standpoint of capital cost, equipment makes up the largest item of expense for our departments. Some dietitians may go into a department already equipped with a budget set up to replace equipment which wears out; hence they may not fully realize its money value or what its life expectancy means in dollars and cents to the institution. Employes must be trained to use machines properly, to report immediately all faulty or damaged equipment before further damage is done. A periodic check by the engineering staff and regular oiling on an engineer's schedule should be established for every machine, for neglected bearings and motors that burn out are expensive items of "hidden costs." Routine visits of service men from the firms that manufacture the various pieces of equipment may forestall breakdowns and lengthen the life of equipment. The best source of information on proper care comes from the manufacturer, and a file of such instructions should be kept and used.

Too frequent painting of walls is necessitated by careless washing of these walls. Some acoustical materials are damaged and their properties are lessened unless special care is exercised in cleaning. Oily polishes may so penetrate certain woods as to make it difficult to remove the old finish when necessary.

The costliest item in the operating budget today is labor. Hidden costs arise here when incomplete and incorrect job outlines permit slack periods without production, when lack of supervision permits waste of time on the job, and when lack of training permits time-wasting methods of work. Nor should we pay labor on "a year after year basis" to do what can be done by a machine whose cost may be no more than a few months' or a year's salary of the displaced employe, yet which goes on producing without complaint for years. The current tendency to analyze the dietitian's job and to use clerical or nonprofessional workers for many of her heretofore routine responsibilities should be extended to other areas. Some of the duties of skilled workers, such as cooks, may be relegated to less highly paid workers.

Many items of prepared food, of frozen foods, will prove to be easy on the budget when the labor cost is considered. Competitive bids from more than one firm, *at the time we buy*, not last week, is our only safeguard against paying too much. One must also know the yield and cost per serving before buying. Miss Eck emphasized anew the need for standardized recipes and reasonably accurate forecasts of the customer count to combat that other "hidden cost," overproduction. Portion control, too, must prevail at the serving table. All these factors are self-evident to the alert dietitian.

There is another large item of expense, however, of which many may not be sufficiently aware. Miss Eck referred to the miscellaneous supplies: cleaning, paper tray covers and napkins, and so forth. "In no area is the effect of what I call multiplicity of expense so important . . . these items are used for every meal, day after day." Hence lack of control multiplies the pennies wasted tremendously. "We must make our supervisors and employes understand the effect of multiplicity—the ultimate cost of spending one more penny on the cost of every patient day multiplied by all the patient days of the year, or 5 cents wasted by each employe per day multiplied by all the employes and then by the 365 days of the year."

Among the more than 70 sessions, conferences, panel discussions and so on, a few choice but quite unrelated gems of thought and wisdom stand out for attention here. Quoted out of text, the reader can only guess at the context, or take the quote at its isolated value. Said Ritz Heerman at the opening session: California's health facilities are now 45,000 beds short; by 1960, 850,000 additional beds will be needed—there were 3,000,000 newborn in California hospitals last year!

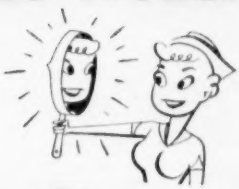
Said Robert R. Gros, advertising man and principal speaker at the open-

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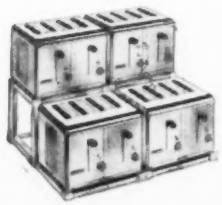
All the toast you need when you need it! No matter how many patients you serve, there's a "Toastmaster" Toaster to suit your exact needs. The 16-slice model pops up 1000 slices per hour; the 4-slice size, 250. Fast service of perfect toast pleases patients, helps step-up your entire food service schedule.

You're sure of perfect toast with the "Toastmaster" Toaster! Every slice is golden-brown, delicious and usable. That's because you make toast as you need it—*where* you need it. "Toastmaster" Toasters fit where you want them, to speed service . . . in the main kitchen and in your floor diet kitchens. Toast for each floor is made *on that floor*. And patients enjoy hot, appetizing toast every time!

Saves electricity too! Each pair of slots is individually controlled. Current goes "on" when bread is lowered; "off" the instant it's done. Electricity is used only while toasting . . . and only in the slots actually in use.

More for your toaster money today and tomorrow! Thanks to "Toastmaster's" unique "Add-a-Unit" plan, you can save real money. Buy the size you need today, then add 2-slice or 4-slice units as your needs increase.

Your food service equipment dealer will be glad to show you the "Toastmaster"* Toaster best suited to your needs. Call him today.



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$416.00†
(1000 slices per hour)

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No time lost, watching or waiting! The "Toastmaster" Toaster is completely automatic—watches itself. Your help is left free for other duties.

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ing session: "Food may shape our ends, but it also ends our shapes," and later in a more serious vein, "The only kind of idealism that works today is strict realism"—his subject, "Freedom Is Never Free."

Much later in the week at a gathering of small hospital dietitians discussing their problems with purchasing *and* purchasing agents, the policies and politics involved, Mrs. Cora E. Kusner, Colorado State Hospital, cautioned: "Life is largely a matter of compromise. You have to meet the situation as you find it, you need to be realistic and to prove yourself first, then see what you can do about the situation." Another quote, this one from an informal discussion group led by Mrs. Jane Sedgewick Pirkey, food administrator for the State of California Youth Authority, was: "To succeed with the management of employes in an institution you must first be accepted by the tribal leader—occasionally he is the superintendent, more often he seems to be the superintendent's secretary, at times he may be the night guard."

Still more, this time from the state of Washington, Margaret Terrell speaking: "When the administrator approves the budget on the basis of accurate information, he then takes the responsibility for approving the standards possible on that budget," and "A cook's casual additions can play havoc with cost accounting; hence the need for standardized recipes." "Controls help to remove temptation—theft may mean a double loss, not only the item, possibly tempting yet low in cost, but also the worker ordinarily efficient." And finally, again from California, Genevieve Callahan, dietitian magazine writer and food consultant: "Get away from that word 'cafeteria,'" said she, "call it buffet service and the food will taste better!" As Mr. Schmidt said earlier in the week, "Women are more creative than men but only when the need moves them."

The dietitian's professional and cultural interest in the basic science of nutrition and dietetics was reflected in the tribute to Dr. James Lind, the first great experimental nutritionist, the founder of naval medicine and hygiene, and one of the founders of tropical medicine. According to Anthony J. Lorenz, director, Nutrition Research, Sunkist Growers, Inc., Los Angeles, Lind, Scottish physician who conquered scurvy, and whose classic "A Treatise of the Scurvy" was published 200 years ago, reported "a brilliantly conceived and most accurately conducted clinical experiment" and served to take the guesswork out of the confused treatment of what was once the most prevailing and debilitating disease of temperate climates.

Lind's experiment aboard a British man-o'-war categorized "deficiency diseases" by proving that a lack of a nutritient could *cause* and the presence of the same nutrient could *cure* as dread a disease as scurvy. The empiric dietetics that prevailed before was characterized chiefly by negative admonitions.

Another great discovery 100 years later, that of the Frenchman, Claude Bernard, who explored the mechanism of glycogenesis, was also commemorated in a scholarly address by Dr. James M. D. Olmsted, professor of physiology, University of California. Bernard's early interest in the transformation of carbohydrate foodstuffs in the living body brought about his discovery that, contrary to prevailing theories, sugar was a normal product

(*Continued on Page 166*)

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CREAM DESSERTS, with sugar and milk, Lemon, Chocolate, Butterscotch, Vanilla, Tapioca and Asst'd.

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CHOCOLATE SYRUP
HOT FUDGE
SPICES
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EXTRACTS
COLORINGS
SALAD DRESSINGS
MAYONNAISE
FRENCH DRESSING
THOUSAND ISLAND DRESSING
MALTED MILK, plain



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ideas

from Blickman-Built award-winning food service installations

"planned work flow" promotes kitchen staff productivity

AT BETH-EL HOSPITAL, BROOKLYN, N. Y.



COOKING SECTION, MAIN KITCHEN: Food conveyor traffic flows rapidly around this section in a counter-clockwise direction. Ample work surfaces are provided by the generously-proportioned cooks' tables. Note seamless work tops, rounded corners, welded tubular undershelves.

● Careful planning, based on work flow studies, is the key factor in the successful operation of Beth-El Hospital's food service installation. Both layout and equipment have been designed to function like a factory production line in serving approximately 50,000 meals per month. Large work areas with wide traffic aisles ensure rapid work flow and increase the productivity of kitchen labor. The modern stainless steel equipment embodies important features of utility and sanitation. These not only facilitate the overall operation, but reduce cleaning and maintenance costs as well.

Service to patients is provided through a decentralized system. Electrically-heated food conveyors are wheeled around the island cooking section in a counter-clockwise direction. They are loaded with foods at the cooking center, bakery and finally the daily stores section. Then, they are taken to individual floor pantries where set-up trays are loaded and placed in tray carts for distribution to patients. Each floor pantry is completely equipped with short order units, refrigerators, dish storage and washing facilities.

This installation, winner of a Merit Award in the 1952 Institutions Food Service Contest, was designed and equipped by S. Blickman, Inc. You, too, can attain top efficiency and economy in your dietary department by installing "Blickman-Built" equipment.



***Send for illustrated folder** describing Blickman-Built Food Service Equipment — available in single units or complete installations.*

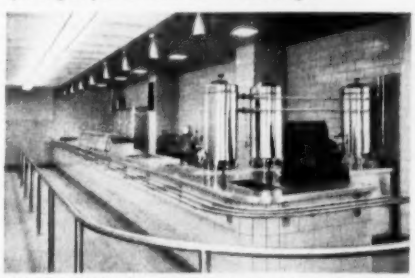
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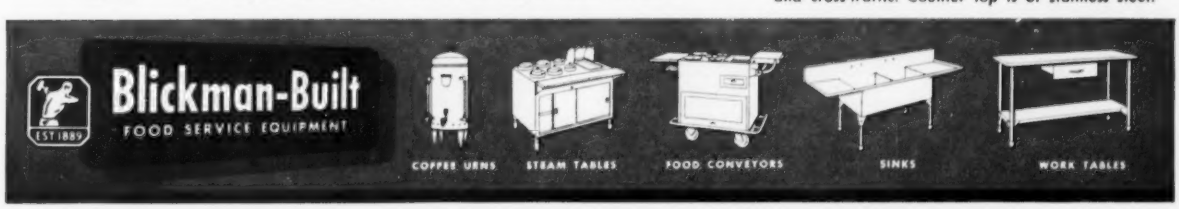
STAINLESS STEEL DISH TABLES in dish pantry. Work top and raised rolled edges form a continuous, crevice-free surface to assure maximum cleanliness.



POT SCULLERY — Close-up of round-corner stainless steel pot and pan sink. Compartments, drainboard and back splash form one continuous crevice-free surface, simplifying cleaning. The sliding tray permits placing of pots at convenient work height.



STAFF CAFETERIA accommodates visitors as well as hospital employees. Pass-through refrigerator at rear provides access to kitchen, eliminating waste motion and cross-traffic. Counter top is of stainless steel.



See the Catalog of Blickman-Built Food Conveyors in the Hospital Purchasing File

Menus for November 1953

Ruth M. Daniel
Dietitian
Halifax District Hospital
Daytona Beach, Fla.

1 Orange Juice Farina, Toast • Kidney Bean Soup Croutons Fried Chicken Mashed Potatoes Stuffed Celery Hearts Strawberry Sundae • Vegetable Soup, Salted Crackers Escalloped Potato With Sliced Frankfurters Mixed Vegetables Frozen Fruit Salad Chocolate Meringue Pudding	**2** Broiled Grapefruit Coddled Eggs, Bacon • Cream of Celery Soup Broiled Liver and Bacon Parsley Creamed Potato Buttered Onions Chef's Salad Apricot Upsidedown Cake • Apple Juice Broiled Ham Baked Sweet Potato Celery, Apple and Date Salad Guava Paste, Cream Cheese, Crackers	**3** Tomato Juice Poached Eggs, Bacon • Alphabet Soup Roast Leg of Lamb Pineapple Mint Sauce Delmonico Potato Peas With Mushrooms Grapefruit Salad With Roquefort Dressing Jelly Roll With Whipped Cream • Lentil Soup Baked Chicken Pie Buttered Asparagus Cuts Beet and Egg Salad Fruit Compote	**4** Fresh Grapes Oatmeal, Broiled Ham • Chicken Noodle Soup Glazed Meat Loaf Steamed Rice Green Beans Polonaise Pineapple Salad Blueberry Pudding With Foamy Sauce • Spanish Soup Creamed Chipped Beef on Rusk Double Baked Potato Lettuce Wedge, 1000 Island Dressing Fruit Gelatin	**5** Sliced Bananas Omelet, Sweet Rolls • Minstrone Soup Broiled Sirloin Steak French Fried Potatoes Buttered Broccoli Carolina Salad Chocolate Chiffon Pie With Whipped Cream • Vegetable Juice Baked Stuffed Peppers Lima Beans in Cream Asparagus and Egg Salad Ambrosia	**6** Honey Dew Melon Poached Egg, Bran Muffin • Clam Chowder Broiled Flounder With Onion Butter Au Gratin Potato Chopped Greens Tomato and Avacado Salad Baked Carrot Pudding With Foamy Sauce • Vegetable Soup Escalloped Oysters Buttered Wax Beans Tossed Green Salad Date Torte
7 Prunes and Raisins Farina, Bacon • Julienne Soup Meat Pie, Vegetables Parsley Rice Buttered Tiny Beets Stuffed Fig Salad Orange Pudding • Cream of Tomato Soup Lamb Patt'e With Caper Sauce Baked Sweet Potatoes Cabbage Salad Chocolate Bread Pudding	**8** Grapefruit Sections Eggs, Cinnamon Roll • Scotch Broth With Barley Roast Chicken French Style Green Beans Celery Hearts and Olives Cloverleaf Rolls Maple Pecan Ice Cream Ice Box Cookies • Cream of Corn Soup Ham and Macaroni Roll Mashed Turnips Waldorf Salad Pear and Plum Compote	**9** Kadota Figs Farina, Bacon • Bean Soup Chopped Steak With Mushroom Sauce Steamed Rice Buttered Asparagus Banana and Bing Cherry Salad Chocolate Fudge Pudding • Cream of Celery Soup Veal Cutlet Baked Idaho Potato Buttered Cauliflower Vitamin Salad Peach Shortcake	**10** Pineapple Juice Ham, Raisin Muffins • Grape Juice Turkey à la King on Rusk Cranberry Sauce Mashed Potatoes Brussels Sprouts Spiced Peach Salad Deep Dish Apple Pie • Vegetable Soup Grilled Canadian Bacon Baked Sweet Potato Pear and Cherry Salad Tapioca Pudding	**11** Sliced Bananas Poached Egg, Bacon • Tomato Bouillon Veal Birds Browned Potato Balls Creamed Celery Sliced Carrot and Beet Salad Cream Puffs • Cream of Mushroom Soup Smoked Tongue With Raisin Sauce Broiled Tomato Pineapple and Avocado Salad Baked Apple	**12** Orange Juice Egg, Bran Muffin • Cream of Onion Soup Roast Pork and Cranberry Jelly Candied Sweet Potato Baked Eggplant Crab Apple Salad Prune Whip With Custard Sauce • Cream of Celery Soup Baked Chicken Roll Spinach With Egg Asparagus Salad Sliced Peaches Cookies
13 Papaya With Lemon Eggs, Corn Muffins • Tomato Juice Baked Red Snapper in Lemon Butter Macaroni and Cheese Turnip Greens Corn Sticks Fruit Salad With Coconut Lemon Delicacy • Mulligatawny Soup Welsh Rabbit on Toast Stewed Tomatoes Tossed Green Salad Green Gage Plums	**14** Apricots Hot Cakes, Sirup, Bacon • Chicken Noodle Soup Cubed Steak Mashed Potatoes Browned Onions Stuffed Avocado Salad Coconut Custard Pie • Blended Fruit Juice Cold Ham Potato Salad Cream Cheese Sandwich on Banana Bread Celery Hearts Custard	**15** Vegetable Juice Omelet, Blueberry Muffins • Apricot Nectar With Lemon Baked Chicken Candied Sweet Potato Summer Squash Pickled Beet Salad Hot Fudge Nut Sundae • Vegetable Soup Escalloped Dried Beef and Rice Buttered Broccoli Apricot and Stuffed Date Salad Chocolate Cake Squares	**16** Prune Juice With Lemon Oatmeal, Bacon • Chicken Gumbo Soup Braised Short Ribs of Beef With Noodles Cauliflower au Gratin Spiced Apple and Cream Cheese Salad Cherry Cobbler • Cream of Split Pea Soup Broiled Chicken Livers and Bacon Carrot Sticks Baked Onions Date and Marshmallow Roll	**17** Grapefruit Half Coddled Egg, Bacon • Julienne Soup Roast Beef au jus Mashed Potatoes Perfection Salad Chocolate Sundae Pie • Minted Fresh Fruit Cup Tuna Fish Pot Pie Okra and Tomatoes Lettuce Salad With Russian Dressing Fresh Pineapple	**18** Grapes Eggs, Ham • Tomato Bisque Chicken Chow Mein on Chinese Noodles Chinese Cabbage With Roquefort Dressing Raspberry Sherbet Ice Box Cookies • Cream of Chicken Soup Giblet and Noodle Casserole Hubbard Squash Jellied Stuffed Pear Salad Applesauce
19 Fresh Fruit Cup Eggs, Sweet Roll • Beef Noodle Soup Rolled Veal Shoulder Mashed Potatoes Stewed Tomatoes Stuffed Celery Salad Neopolitan Slices • Apple Juice Grilled Platter of Ham, Pineapple and Sausage Baked Sweet Potato Deviled Egg Salad Fruit Compote	**20** Sliced Bananas Bran Flakes, Egg • Oyster Broth Broiled King Fish With Lemon Corn Pudding Buttered Peas Sliced Tomato Salad Lemon Meringue Pie • Cream of Tomato Soup Salmon Loaf With Egg Sauce Mixed Vegetables Chef's Salad Fruit Cup	**21** Sliced Oranges Baked Eggs in Cream • Papaya Juice Baked Meat Pie French Fried Eggplant Baked Acorn Squash Whole Green Bean Salad Chocolate Eclair • Cream of Celery Soup Chicken Soufflé Lima Beans Peach and Cream Cheese Salad Orange Fruit Gelatin	**22** Baked Apple Ham Omelet, Sweet Roll • Grape Juice Roast Turkey, Dressing Cranberry Jelly Mashed Potatoes Frozen Fruit Salad Ice Cream Sundae in Meringue Shells • Vegetable Soup Tuna Fish Salad Potato Chips Broccoli au Gratin Fruit Gelatin	**23** Apricot Nectar Eggs, Bacon • Chicken and Rice Soup Lamb Chop With Mint Jelly Parsley Creamed Potato Buttered English Peas Sugar Plum Salad Strawberry Chiffon Pie • Fruit Punch Deviled Eggs and Tomato Sauce Wax Beans Hawaiian Salad Floating Island	**24** Peach Halves Poached Egg, Bacon • Pineapple Juice Beef Stew, Vegetables on Hot Biscuits Mexican Corn Lettuce Wedge, 1000 Island Dressing Chocolate Ice Cream Roll • Split Pea Soup Creamed Turkey on Chinese Noodles Spinach Tomato and Avocado Salad Pear Halves
25 Orange Juice Omelet, Bacon • Vermicelli Soup Country Steak Mashed Potatoes Stewed Tomatoes Jellied Fruit Salad Frozen Custard • Celery Consommé Baked Macaroni & Cheese Green Beans Celery, Apple and Ham Salad Baked Banana in Lemon Sirup	**26** Sliced Orange Frizzled Ham, Muffins • Fresh Fruit Compote Roast Turkey, Gravy Cranberry Sauce Mashed Potatoes Combination Salad Celery Hearts and Olives Pumpkin Pie With Whipped Cream • Cream of Mushroom Soup Stuffed Tomato Salad Cold Sliced Turkey Potato Chips Radishes Chocolate Sundae	**27** Grapefruit Juice Poached Egg • Coquina Broth Fried Trout With Tartare Sauce Boiled Rice Cabbage and Pineapple Salad Lime Chiffon Pie • Cream of Vegetable Soup Creole Shrimp Double Baked Potato Whole Kernel Corn Lettuce Wedge, 1000 Island Dressing Fruit Compote	**28** Stewed Prunes Scrambled Eggs, Bacon • Beef Noodle Soup Chopped Sirloin With Mushroom Sauce Creamed Potato Balls Buttered Onions Lettuce and Tomato Salad Coconut Bread Pudding • Cranberry Juice Broiled Ham Chopped Turnip Greens Pineapple and Grape Salad Apple Krumble	**29** Grapefruit Sections Coddled Egg, Muffin • Consommé à la Royal Barbecued Chicken French Fried Potatoes Cauliflower With Cheese Sauce Celery and Carrot Sticks Ice Cream Pie • Cream of Lima Bean Soup Cheese Soufflé Buttered Peas and Carrots Orange and Date Salad Kadota Figs and Marguerites	**30** Orange Juice Hot Cakes, Sirup • Duchess Soup Liver and Bacon Patties Mashed Potatoes Buttered Beets Apricot Salad Paradise Pudding • Vegetable Soup Baked Chicken, Noodles Spinach With Egg Wedge Tossed Salad With Roquefort Dressing Graham Crackers and Banana Pudding

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KRAFT Foods Company INSTITUTIONAL DIVISION

The Nation's Taste Is Your Best Buying Guide

Shrimp with Cheez Whiz

Heat whole cooked shrimp, chopped onion and chopped green pepper in butter, tossing lightly. For each serving place the hot shrimp mixture on 2 toast triangles and cover with hot Kraft Cheez Whiz.



Upkeep of Patients' Rooms

goes smoothly under this system

HERBERT D. KLEIN
Plant Superintendent
Massachusetts Memorial Hospitals
Boston

DID you ever compare your hospital to a fine hotel? When you think about it, there are many similarities. Both afford rooms and "room service."

In order to keep the hospital's guests happy and satisfied, all areas must be clean and attractive at all times. When the census remains high, a heavy burden falls on the shoulders of the housekeepers and maintenance department. Often a room is vacated in the morning and before evening a new patient will have to be moved in. When can repairs be made, paint touched up, and wallpaper patched? How much upkeep can be accomplished while the room is occupied? Yes, occupied! At the Massachusetts Memorial Hospitals, repairs are a continuing function.

A new division of the maintenance department was created a year ago. Dubbed "Upkeep Division," it is a unit consisting of three men whose duty it is to keep patient areas and public areas in good repair. One member of the group is an experienced carpenter-mechanic and is able to handle any form of minor repair except those of a plumbing or electrical nature. Assigned to the carpenter is a painter able to handle touch-up jobs and repairs to all forms of wall covering. The third man on the team is the hospital's "Mr. Fixit." His duties carry him through the hospital from top to bottom daily on a regular schedule. He is able to cope with any form of minor repairs to plumbing, electrical or mechanical installations.

Each man on the team has his own rolling work bench, equipped with materials and tools. Each is dressed in attractive white coveralls, which are changed daily. The men not only are accomplished in their fields but have been chosen because of their ability to maintain a cheerful, friendly attitude in the presence of patients.

The major problem of providing immediate repair service was not in getting the right people but, rather, in getting the necessary information to the mechanics. This problem was solved with the cooperation of the nursing and housekeeping departments. When a patient is to be discharged, the nursing department immediately contacts a housekeeping supervisor. Housekeeping then "carries the ball" until the room is again ready for occupancy.

Left: The hospital's Mr. Fixit replacing a fluorescent tube in a corridor light. Center: The enclosed cart shows all hospital colors handy for touch-up work by the paint and paper patcher. Right: Private room undergoes a thorough check-up by the carpenter-mechanic. He uses a maintenance check list as a guide and checks off each item.





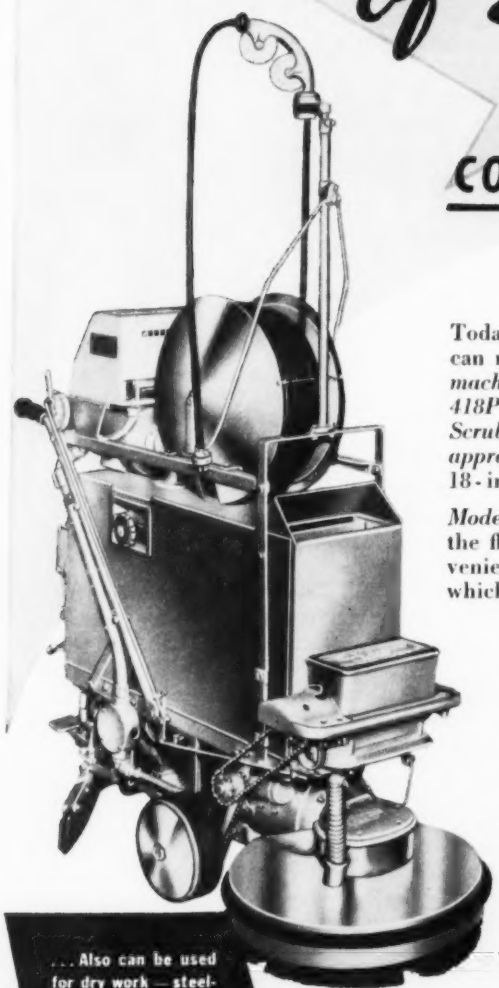


SMALL-AREA BUILDINGS...

Save 2/3 of Every Hour of Scrubbing Time

WITH A

COMBINATION SCRUBBER-VAC!



...Also can be used for dry work — steel-wooling, et cetera

Today, even buildings with but 2,000 to 15,000 sq. ft. of floor space can reap the labor-saving, cost-reducing benefits of *combination-machine-scrubbing.* Here's a *Combination Scrubber-Vac, Model 418P* at left, that's specially designed for such buildings. This *Scrubber-Vac,* which has an 18-inch brush ring, cleans floors in *approximately one-third the time* required with a conventional 18-inch machine and separate vac unit.

Model 418P applies the cleanser, scrubs, and picks up (damp-dries the floor) — *all in one operation!* Maintenance men like the convenience of working with this single unit... the thoroughness with which it cleans... and the features that make the machine simple to operate. It's *self-propelled,* and has a *positive* clutch. There are no switches to set for *fast* or *slow*—slight pressure of the hand on clutch lever adjusts speed to desired rate. The powerful vac performs efficiently and quietly. (Powder dispenser is optional.) Compactly built, the *418P* also serves advantageously in larger buildings for the care of floors in narrow aisles and congested areas.

Finnell makes *Scrubber-Vac Machines* for small, vast, and intermediate operations, and in *self-powered* as well as *electric* models. From this complete line, you can choose the size and model that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that you can lease or purchase a *Scrubber-Vac,* and that *there's a Finnell man nearby* to help train your maintenance operators in the proper use of the machine and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1410 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

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Massachusetts Memorial Hospitals

Maintenance Check List

UPKEEP UNIT

Bldg. Col Room 4 Floor 6 Ordered by Dr Thayer Date 2-11-58

ITEM	WHAT IS WRONG	Carp. Mech.	Painter	O.K.	Insp.
(1) Doors — hdwre, frame, transom, stop, check, hinges, knobs, lock, door, casing	Paint				
(2) Window — glass, frame, screen, shade, hdwre, cord, storm unit, blind chain, drapes					
(3) Floor — baseboard, asphalt tile, linoleum, terrazzo, vinyl, rubber, granite, ceramic					
(4) Walls — Trim, wallpaper, chair rail, Ceiling, plaster	replace paint trim				
(5) Furniture — bed, casters, bumpers, chair, side table, bureau, o.b. table, bed crank, mirror, stool, handle					
(6) Plumbing — sink, faucets, stopper, tub, hopper, tank flushometer, drain	toilet seat loose				
(7) Heat — Radiator, valves, pipes, traps, insulation, noisy, paint peeling, leaking	screws loose paint				
(8) Electrical — switch, nurses call, wall lite, overhead lite, floor lamp, outlet	replace shield				
(9) Miscellaneous	replace shade pull bathroom				
	Remove picture (nail near bathroom)				
DID YOU CLEAN UP BEFORE LEAVING? CONSIDER THE PATIENTS' COMFORT	PLEASE DOUBLE CHECK	✓	✓		

Form used by the housekeepers as a check list for upkeep division.

A minute inspection is made of the room as the cleaning procedure gets under way. With a maintenance check list as a guide, any needed repairs are noted and the list is then turned over to the upkeep division for execution.

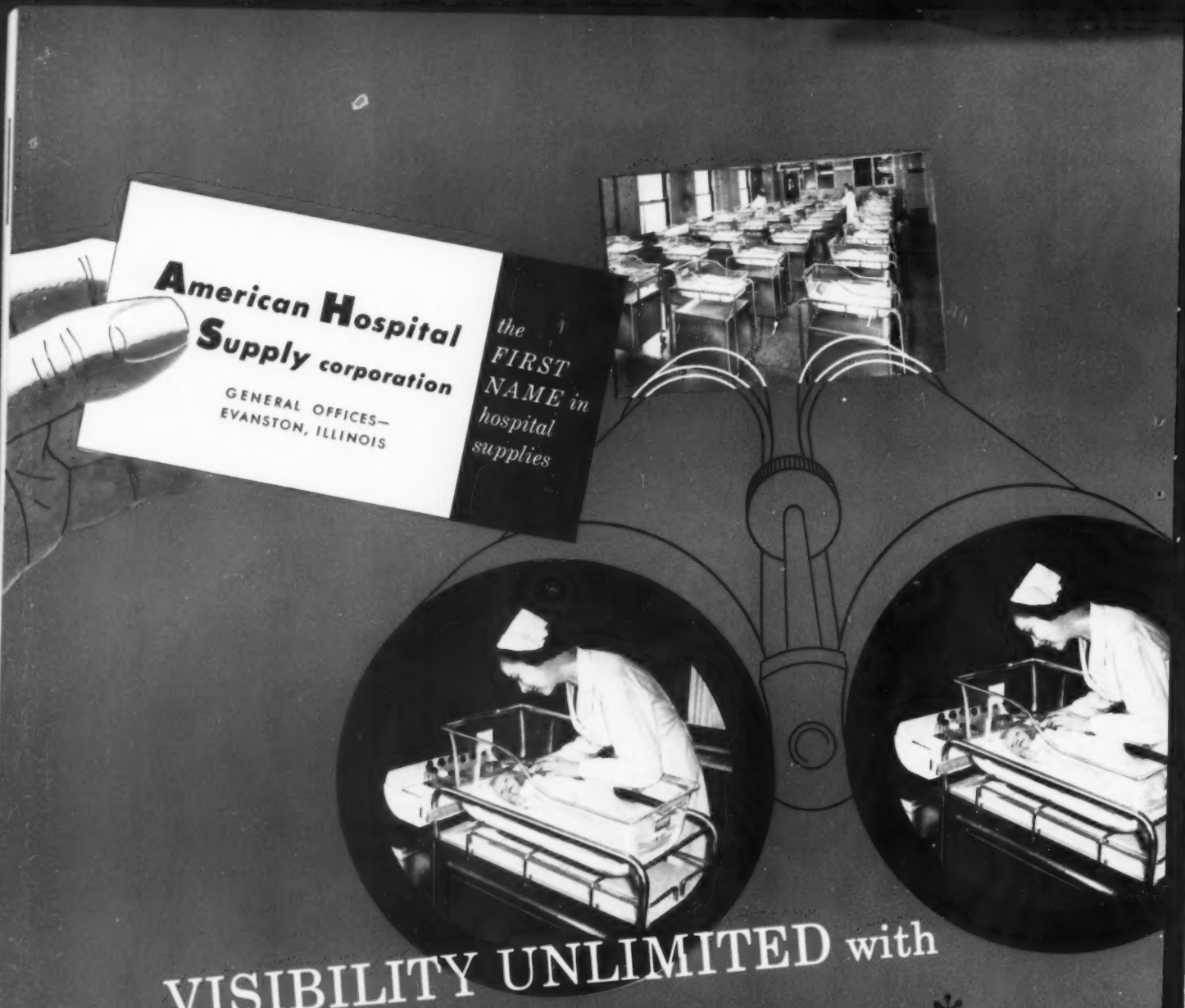
In addition to the check list form for requesting repairs, every important station in the hospital has a book for listing repairs to be done by the Fixit Man. In general, small repairs are handled within 24 hours without a telephone being used, a work order being filled out, or the maintenance chief being made aware of them until after they are completed. Upkeep generally is carried on even if the room or ward is occupied. If a patient is too ill to be disturbed, repairs are deferred temporarily; however, we have found that a repairman is usually welcomed as an interesting diversion to normal hospital routine. Most people are "sidewalk superintendents" at heart.

To best illustrate how this program functions, let us take a typical day at Massachusetts Memorial Hospitals and see just what this upkeep unit does.

At 8 a.m., upkeep men report for work, don clean uniforms, and check their rolling work bench to be sure necessary supplies and tools are in place for the day's work. The Fixit Man and the painter immediately handle any tasks that haven't been accomplished from the previous day. The carpenter-mechanic reports to the housekeeping office to pick up the day's assignments. He goes over each request to determine whether it will be handled by the Fixit Man, the painter, or himself, and to determine job sequence, if multiple operations are necessary to complete the job. He then distributes the work, and the day progresses. Occasionally, he will be interrupted to handle a recent patient discharge. The decisions as to job priorities are made by him.

If the carpenter-mechanic has gone into a room to repair a door casing or


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DYNAKLEN
DETERGENT
QUICK ACTING • EASY TO USE
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Read directions before using.
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MADE IN U.S.A. FOR
AMERICAN HOSPITAL SUPPLY CORPORATION
GENERAL OFFICES - EVANSTON, ILLINOIS
. . . a safer, faster more effective cleaner for surgical and laboratory equipment
• No more rubbing or scrubbing of instruments and glassware. Simply soak in Dynaklen solution and rinse. Dried blood, plasma, serums, pyrogens are all removed completely, leaving glassware and instruments chemically clean.
Dynaklen saves money, too, because just one ounce makes a gallon of solution that can be used at once or stored indefinitely.
Safer, too . . . Dynaklen contains a non-active coloring to prevent possible confusion with other uncolored chemicals.
removes Pyrogens!



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For convenient approach to the operative site—
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a window frame, as soon as his work is completed the painter follows him to handle touch-up. All these men realize that to a patient lying in bed minor defects appear to be major overhauls and that it is their duty to see that the rooms are kept in the best repair humanly possible without creating a disturbance.

Mixing paint colors, which is time consuming, is not practiced at the Massachusetts Memorial Hospitals. We have 15 accepted hospital colors, and these are used with few, if any, deviations; therefore, painting touch-up is no major problem. All rooms are catalogued according to paint and paper, so it is a simple matter to determine what colors are required for the touching up job.

CHECK ON REPAIRS

As the work day draws to a close, completed upkeep forms are collected and turned over to the chief of maintenance. The purpose of this daily return is not only to keep the maintenance supervisor informed of repairs that have been accomplished, but also to determine how often a typical repair is required.

This team of three men is instructed to list major repairs beyond their scope so that they may be handled through regular work-order channels. Information that normally would not appear until a major breakdown occurred now filters into the maintenance office and affords a preliminary warning.

The advantages of this type of program have been many. The saving in cost by catching small repairs before they develop into large ones is indeterminable; however, it is obvious that there is a saving. Work-order flow to the maintenance department from all other departments has diminished considerably. The efficiency of repairing has improved because considerable time is saved for our regular mechanics who are now able to do other work. The appearance of the hospital has improved and, as a result, we have more satisfied patients and improved morale and efficiency on the part of all personnel.

The reason for improved employe efficiency and morale is more or less obvious. Repairs that used to be done by means of normal work orders would naturally take time. Now we are able to give service in many cases within 24 hours after it has been brought to the attention of the upkeep division.



Ceco-Meyer Steelform Service cuts costs 11% . . .





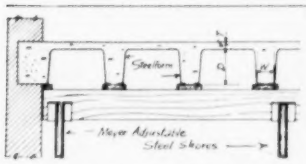


Ceco-Meyer Steelform Service was used in these 3 buildings.

Economy in building is important, even to a great institution. So, when Schmidt, Garden and Erickson, Architects, designed three units of a medical center in Chicago, several methods of constructing floor systems were studied. Ceco-Meyer Steelform Service was selected because it offered definite savings. But let them tell the story.

"We made an analysis of several types of construction," say the architects, "including slab-beam-and-girder, solid slab and several others. When the figures were on paper, concrete joist construction showed a saving of 11% in the concrete frame. Ceco was selected to provide Meyer Steelform Service. J. W. Snyder Company, General Contractor, made the indicated savings realistic."

"To complete a major hospital job on time," says Constructor Victor Snyder, "there must be close cooperation between architect, constructor and a supplier who understands our joint problems. Such a firm is Ceco . . . their construction knowledge in the field, and ability to perform, got them the job."



cross section *Less steel, concrete, lumber, labor with Ceco-Meyer Steelform Service.*

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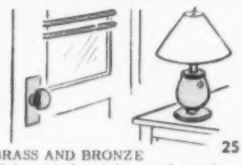
SAVE THE SURFACE AND YOU SAVE ALL

Surfaces are not all alike. Some are more delicate than are others. Be guided by their weaknesses...before you start to "polish them off."



24

ALUMINUM
Know your aluminum. Some qualities need only ordinary washing, rinsing, and drying off to be beautiful. Others not so good show every water spot. Poor aluminum needs rough treatment. Often an abrasive must be used.
Water may be very hot. Wax will add nothing to its beauty.



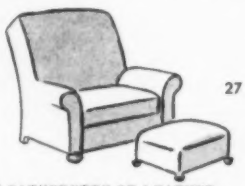
25

BRASS AND BRONZE
Water need not be used on these surfaces. They respond better to Brass Polishes. To clean, cover the soiled metal with a small amount of polish...allow to dry...then wipe off with a dry cloth. Use template to protect wall when necessary...



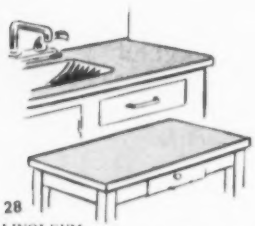
26

CHROME
Chrome is filled with tiny pores. Wash with mild soap solution in hot water, rinse well and dry. After drying, apply small amount of oily furniture polish...which keeps air moisture out of the pores.



27

LEATHERETTE OR LEATHER
Wash leatherette with warm water and mild soap, getting deep into the tiny recesses. Rinse and dry well. Apply a tiny bit of furniture polish. Leather should be washed with saddle-soap, which preserves it.



28

LINOLEUM
Use care in washing and in rinsing. Follow Moppy's and Waxey's cautions...tepid water, mild soap, good rinsing, dry and apply a little water wax. Hand polish the wax into a shining surface.



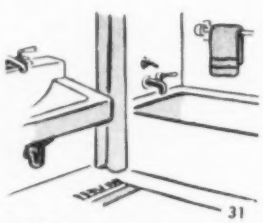
29

MARBLE
Marble is porous and must be carefully washed. First apply clear water to fill pores. Then wash with mild soap using small amount of fine abrasive if necessary. Rinse, and polish dry with soft cloth. Use soft brush to remove stubborn soil.



30

PAINTED METALS
This sort of furniture has only a very thin layer of paint and requires gentle washing. Use tepid water...a neutral soap solution...rinse well and dry well. Finish with a small amount of furniture polish upon a clean polishing cloth.



31

PORCELAIN
This is not as tough a material as most people imagine...it requires gentle treatment.
Use only a mild soap...or a very finely ground abrasive powder...clean cloths. Wash gently...rinse well...dry well.

The V. A. Sets Up Housekeeping

TRAINING MANUAL ON DUSTING—II

FOUR Housekeeping Training Guides, covering sweeping, dusting, waxing and mopping, have been developed by the Veterans Administration for use in its hospitals. In this issue The MODERN HOSPITAL presents the second section of the manual on dusting. The manual on sweeping appeared in January, February and March, and the mopping guide was presented in five sections — April through August. The third section of the dusting manual will appear in the November issue of this magazine.—ED.

24. It is easy to confuse one metal with another, especially when they are not coated with some easily identified material. Aluminum is often confused with other "silvery" metals, which might be stainless steel, monel, lacquered tin or nickel.

Aluminum finishes are often deceiving. Some have unequal parts of the necessary alloys and this imbalance may present cleaning difficulties. Some articles are marked "aluminum finish" and they may not be of the basic aluminum at all. They may be of one of the inferior metals which is lacquer coated to give it the sheen of shiny aluminum. Once this lacquer coating is broken and the metal is exposed, the cleaning problem increases. It is not uncommon for this basic material to be of a type which gets stained with each drop of water, and the water spots can be removed only by abrasive cleaning. This type of cleaning will continue to be necessary until such time as another coating of clear lacquer is applied.

Another type of aluminum contains some of the steel alloys which makes it as easy to clean as stainless steel. This kind presents no special problems.

Dusty advises that before you assign dusting jobs you should first determine the quality of the aluminum to be serviced.

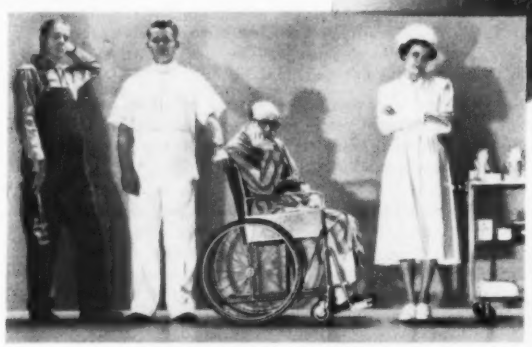
25. There are a variety of items made of these metals since they are considered both decorative and practical. When brass and bronze are used for hardware they are hard to clean and polish because the polish is easily spattered onto the adjacent surfaces. The worker's skill must be so developed that spattering will not occur.

In larger pieces, such as bronze plaques, the soils are blown into the indentations and into the small corners around the lettering and are often hard to remove. The first step in cleaning is first to brush out the impacted corners with a fairly stiff brush. Then, before the brass polish is applied, make some provision to protect the area surrounding the plaque.

Only Kalistron

FINEST PLASTIC COVERED [illegible]

can protect your walls from this Wrecking Mob



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No wonder demand has DOUBLED this year for beautiful, decorative, "wipe-it-clean" Kalistron

Once and for all you can say good-bye to walls marred by scuffs and scratches, scarred by chips, bumps, cracks. Yes, you can protect your walls *as never before* with *glamorous* Kalistron! It's virtually indestructible and never needs repainting.

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1. Kalistron is the toughest wall covering known. Its surface is transparent Vinylite that nothing can visibly scuff or scratch. The color is *underneath* this vinyl armor, unharmed by any kind of roughhouse except deliberate vandalism.
2. Nothing newer, nothing smarter. 33 gorgeous decorative Kalistron colors that, seen through the Vinylite, take on 3rd dimensional depth and beauty.
3. Easiest to maintain. Wipes clean with a damp cloth. Or you can wash it with soap and water. A low cost, long-enduring investment.

Functionally flexible, Kalistron can be mounted to curves, columns or straight walls. Also supplied with 3 way stretch fabric back for matching upholstery use. Hospital executives rave about Kalistron for corridors, patients' rooms (great behind beds and other moveable furniture), kitchens, pantries, waiting rooms, laboratories.



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Without obligation send me nail file test kit and Kalistron sample.

NAME_____

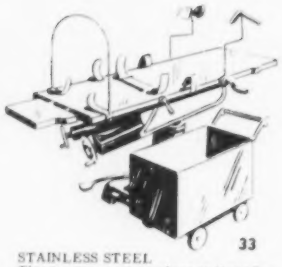
ADDRESS_____

CITY_____ STATE_____



32

PLASTICS
Plastics wash off very easily...no strong soaps...or abrasives are necessary, rinse well...dry well... and polish to a nice sheen.



33

STAINLESS STEEL
This is very easy to clean as it needs no polishing or protective coating. Wash with a mild soap, rinse well, dry smoothly and well. Fingerprints can be taken off with a thin whiting poultice spread over soiled area... allowed to dry on...and rubbed off with a clean, soft, dry cloth.



34

WOOD
Wood is protected with a paint or varnish coating. This painted coating damages easily. It also scratches easily...and thereby requires careful washing.
Washing and polishing procedure:
1. Remove gum wads from underneath.
2. Damp dust inside of drawers.
3. Clean around small parts, such as knobs, gliders, and casters.
4. Wash carefully with tepid water ...mild soap...rinse well...dry well.
5. Use clean, lintless polishing cloth containing just a few drops of furniture polish. Polish thoroughly ...but gently over every inch of this piece of furniture. And last of all, carefully...but thoroughly, finish polishing procedure by giving a last thorough rub-down with a dry, clean, lintless cloth.

A protective device for the surrounding area is an especially made template. This template may be made of any lightweight material which can be made to adhere to this surrounding area: a heavy piece of cardboard, a sheet of tin, a piece of old linoleum, or even a sheet of paper. Shape this template material to butt up snugly to the outside rim of the object to be cleaned; fasten it on, and let it remain in this position until the cleaning and polishing job is completed.

When the template is in position apply the brass polish, allow it to remain on surface according to instructions; then remove it. After the polishing job is completed, remove the template and hand polish the edges where the template has hugged the plaque.

Polish only the brassy part of the plaque. If the background is of some other material do not apply any brass polish to this section.

Rather than perform this onerous chore every day—or even once a week—there is a short cut which is quite popular. This short cut is to lacquer over the bronze part of the plaque immediately after the polishing procedure is completed. The elements will ultimately cause this lacquer to disintegrate (in three to six months) and when this happens it is not much of a job to remove the lacquer completely. Then clean and relacquer.

25. Chrome requires little pampering unless it is poorly chromed. A poor chroming job is evident by the pores which are tiny pits where the basic metal has been left exposed. Rusting of the basic metal takes place in these tiny pits when they are exposed to the moisture in the air and the moisture from the wet cleaning processes. When chrome is thus pitted the only recourse a cleaner has is to protect this pitting with a fine film of oily polish. "Chrome finish" is a deceptive term for it is often not chrome at all. It may be any cheap basic metal which has a simulated chrome finish upon it. This simulated "chrome finish" is just a coating of a silver metallic paint probably top-coated with lacquer. Just as soon as the lacquer coating is broken the metallic paint discolors and no amount of good cleaning will make it look right. It then has to be repainted. Well chromed pieces are the easiest surface that Dusty has to service. They require only a scrubbing out around the corners and crevices—a simple washing and rinsing and thorough drying. They require no further polishing.

27. Leather and leatherette require somewhat different cleaning methods. Leather is an organic substance and leatherette is a form of painted surface. Some of the simulated leatherettes are of the plastic family. Each has its separate peculiarities.

Genuine leather cleaning must be done with a neat's-foot oil base cleaner, which is popularly referred to as saddle soap. This soap both cleans and preserves the leather finish.

Leatherette, since it has a painted surface, must have the same gentle cleaning as paint. Harsh cleaners or rough cleaning methods will cause it to craze and peel off very quickly. In simulating leather in the leatherette materials, the coating is given a rough textured surface. This pebbly surface is quite a dust-catcher. The dust along with the moisture from the air and human perspiration forms into an impacted mass in the recesses of the pebbly surface which at times makes cleaning quite difficult.

It is sometimes necessary to use a soft brush and a cleaning compound which contains a quick emulsifying agent. Softly brush the cleaning solution into the recesses, using only a tepid water. Rinse thoroughly with tepid water; dry well. Finish off with a small amount of nonoily polish. Be especially sure that no residue of polish remains upon the surface which may ruin clothing.

28. One of the features which must be guarded against in the cleaning of a linoleum surface is the use of too much water around the edges. Water must not be allowed to seep under the edges of the linoleum topping.

Because linoleum is composed of linseed oil, it is easily soluble in a spirit type of material. Therefore, use only a nonspirit wax in the final polishing process. This is popularly known as a "water wax."

29. The common opinion about marble surfaces is that they are hard and nonporous. This is not true; they are very porous and absorbent. It is therefore unwise to use cleaning compounds which are at either end of the pH range. However, if the marble surface is extremely dirty, it is sometimes imperative that an effective cleaning compound be used. It is then that the porous area must first be filled with *clear water* before the harsh cleaning solution is applied. If this method is not used the cleaning chemical crystallizes within the pores and ultimately expands as it dries, which causes the marble to spall. Harsh chemicals also leech out marble and cause a discoloring.

30. As painted or "enameled" finishes age they become very brittle and discolored. The older the finish, the greater the inclination to scrub it harder in the hopes of improving its appearance, but harsh cleaning methods just make matters worse. It is a vicious circle.

Dusty proceeds very carefully and gently in order to keep the enameled surface clean and in good condition.

31. Cleaning of the fixtures which are a part of the porcelain surface is one of the time consuming chores in cleaning bath or laboratory porcelain. Fixture cleaning must precede the actual cleaning of the porcelain, otherwise the porcelain will have to be cleaned again.

The fixtures may be made of chrome; if so, use the method of cleaning prescribed for chrome.

If the fixture is made of stainless steel, use the cleaning method prescribed for this metal.

Oftentimes the fixtures are of nickel. This metal never cleans as well as the others mentioned and never attains as high a sheen as do the others. It develops a tarnished appearance and always appears half cared for. Sometimes this tarnished appearance can be improved upon by

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Provides Extra Storage Space

—WITHOUT ADDITIONAL FLOOR AREA NEEDED

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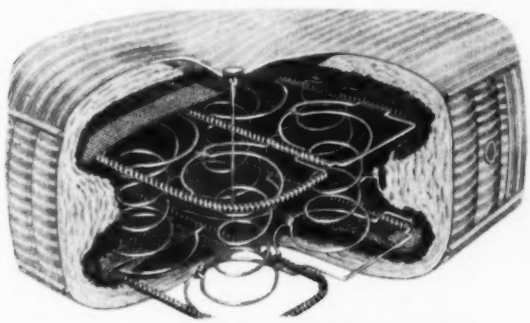
PAT. APP. FOR

All steel ends and storage compartment drawers.

Heights including 3-inch ball bearing casters (standard on this bed).

Head	48 in.
Foot	36 in.
Spring surface	27 in.
Width	3' 0"

CT 4665/4-3 — With Ultra Variable dual crank spring.
CT 4665/3-3 — With conventional crank-operated spring.
CT 4665/2-3 — With 6"-rise link spring and adjustable head rest.
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Minimum maintenance costs can be attained with the **CT 4102** Hospital Mattress. Special hinged innerspring coils allow maximum flexing with every position of spring bottoms; reduce coil friction and give freedom from unit breakdown. Curled hair pads, top and bottom, and white layer-cotton-felt upholstery provide necessary firm quality and surface softness.



All Steel HOSPITAL BEDS

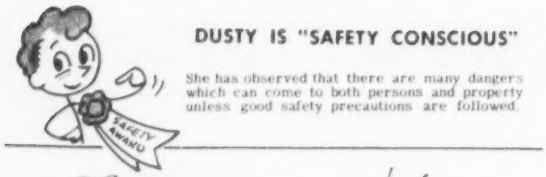
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Used in the widest variety of room furnishing plans, Superior Sleeprite standard style hospital beds have more than proved their satisfactory quality through years of service. Available in a wide range of solid or two-tone solid colors and handsome wood grains. Illustrated above is the **CT 4657/4** Hospital Bed with Ultra-Variable, dual crank spring. Other styles and types of beds and springs available.

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DUSTY IS "SAFETY CONSCIOUS"

She has observed that there are many dangers which can come to both persons and property unless good safety precautions are followed.



35

Humpty Dumpty had such a fall as this... and they could not put him back together again. Check ladders carefully.



36

Careful, don't bust the bust. Handle such valuable articles very, very carefully.



37

The vanishing vase may be something so valuable that it can never be replaced.



38

Beware the contents of the waste basket - it may contain broken glass, razor blades, and other sharp things that can cause considerable damage.



39

Don't get "pinched" while dusting, this is pure carelessness.



40

Pipes and radiators can be "hot stuff", and burns from them can be painful.



41

You need all of your fingers, so don't lop them off while dusting an electric fan. Disconnect it before dusting.



42

Don't over-reach! Avoid a wrenched back by stretching carefully when dusting in high places.

using silver polish; more often it just continues to have that tarnished look.

When fixtures "peel" and the outer coat disappears—and the brass basic metal is all there is left—use the brass cleaning method, and if necessary lacquer it to help it retain its appearance. Faucets and fixtures quickly accumulate impacted dirt and soap accumulations around the crevices. These will have to be hand scraped and scrubbed clean.

The porcelain or vitreous enamel must be kindly treated. It must not have harsh abrasives used upon it. Neither should strong acids or alkalies be used. In the event the vitreous enamel or porcelain becomes stained, obtain from the pharmacy the antidote which will counteract the particular stain. Use it according to instructions, then thoroughly wash off all traces.

32. Plastics are the easiest surfaces Dusty has to maintain. Few materials can harm them.

33. Quality stainless steel absorbs no stains and is therefore very easy to service. It does, however, "fingerprint" easily and removing fingerprints is a never ending process.

Whiting is a washed chalk polishing agent. Your pharmacist will be able to obtain it under the name of calcium carbonate. Make a thin paste of the whiting, spread it on the stainless steel, give it ample time to dry well, then rub off with a clean dry cloth.

34. Wood is protected witn a paint or varnish coating. This painted coating damages easily. It also scratches easily and therefore requires careful washing.

Washing and polishing procedure:

1. Remove gum wads from underneath
2. Damp-dust inside of drawers
3. Clean around small parts, such as knobs, gliders and casters
4. Wash carefully with tepid water and mild soap, rinse well, dry well
5. Use clean, lintless polishing cloth containing just a few drops of furniture polish. Polish thoroughly but gently, over every inch of this piece of furniture. And last of all, carefully but thoroughly finish polishing procedure by giving a last thorough rub-down with a dry, clean, lintless cloth.

35. Unless the worker is well trained in safety precautions she can easily be hurt while doing high dusting. One of the easiest ways to avoid this is to provide long handled dusting tools with which to dust off the high places. Only when this is not feasible should a ladder be used.

When a ladder must be used Dusty advises that it should be inspected first. If it is unsteady it should not be used until repaired.

Does it have nonskid shoes on it so that it will not slide around?

Does it have a firm top step which is amply large for both the worker and whatever tools she may be using? Ladders are important pieces of equipment but they must be in safe condition to use.

36. The custodial employes have so many different types of articles to handle that it is no wonder they occasionally let one of them slip through their fingers. Their hands are often wet or slightly oily from polishes, which invites accidents.

Here the instructor should dwell upon extra care necessary while dusting operations are in progress. It is especially essential that caution be exercised during the lifting of such heavy and cumbersome articles as are pictured here. It is even more important that these falling objects do not fall upon passersby.

37. Here the instructor should present a discussion about values. It is well to point out that some articles which require dusting are irreplaceable.

38. The innocent appearing wastebasket could tell some gory tales if it could talk.

Personnel should be cautioned about the dangerous items which are very often tossed into a basket. These may include broken bottles, razor blades, or most anything. The basket might also contain dirty objects, such as sputum cups, contaminated nose wipes, or soiled dressings, none



There's a layer of safety underfoot with floor wax improved with anti-slip LUDOX®



Here's how "Ludox" adds slip resistance:

"Ludox" is colloidal silica—tough, transparent particles of minute size. The pressure of a footstep forces the hard "Ludox" particles into the softer, larger wax particles. This action absorbs much of the foot's forward-moving energy . . . gives positive traction underfoot.

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If your supplier doesn't have wax containing "Ludox," write Du Pont,4147-MDu Pont Building, Wilmington, Delaware.

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BETTER THINGS FOR BETTER LIVING . . . *THROUGH CHEMISTRY*

HOW TO DUST



43

Make way for good dusting! Remove articles from top surface before dusting.



44

Then dust the furniture surface, or wash it according to its needs.



45

If it must be washed . . . be sure to place a drop-cloth under it so as to absorb all drops of water or solution before it becomes spillage onto the floor. . .



46

Wash and/or polish the small items, then replace them in the same position they were in when you started to dust.

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Brillo solid-disc steel wool floor pads work evenly . . . apply wax or seal smoothly, without streaks or swirls. Daily once-over removes traffic grime—makes original waxing last longer. Gives brilliant finish to linoleum, asphalt or rubber tile, wood, and terrazzo. Sizes for all machines.

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CLEANS BETTER

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BRILLO
SOLID-DISC STEEL WOOL
FLOOR PADS

of which should get upon the duster's hands. Therefore, the wise duster should be continuously reminded that baskets must be emptied without aid of the hands.

This, however, does not mean that the contents of the baskets should be upended and then pounded out, thus damaging the basket. If need be, a small stick should be provided to agitate the contents so that they will fall out easily.

39. There are many places where a duster can pinch herself. There are springs and hinges and door checks and any number of tight places. Chief among these is the bed spring which has so many "pinchy" places. Employes must be forever on guard against hurting themselves.

They should also be on their guard about unintentionally causing near-by persons to get hurt.

40. There are so many, many "hot spots" around a hospital. There are hot pipes, hot stoves, hot sterilizers, hot wax containers, hot pack dressings, apparatus and many other "hot spots."

When dusting around a hot article every precaution should be observed so that no burns will result. Dusty advises that when dusting around (or under) some of these hot areas a long handled dusting tool be used wherever possible.

41. There are many electrical appliances in every part of the hospital, probably none more dangerous than the electric fan. It is so easy to forget to disconnect it before dusting it. The duster must also be extremely aware of the "shock" possibility of damp dusting electrical equipment. It may not be the shock alone that is dangerous, but the jolt may precipitate still another accident.

42. Errors in judgment in reaching or bending during dusting operations have been the source of many sprains and strains. It is so easy to harm oneself. A few cautions from Dusty on this score may be helpful:

(a) Do not stretch too far; spare yourself by using a long handled dusting tool.

(b) Do not over-reach unless you have firm footing; it is so easy to slip and twist your muscles or ligaments.

(c) Also use caution when stooping to dust; you can harm yourself this way, too.

43. There will be much greater assurance that each piece will be dusted if it is first removed from the surface upon which it stands. This also permits much easier washing or dusting of the surface.

If time is at a premium, a shorter method may be followed. In this substitute method the articles are not completely removed, but are just pushed aside. The cleared space is then dusted (or washed), the separate items are quickly dusted (or washed) and they are then returned to their proper place.

44. Then dust the furniture surface, or wash it according to its needs. It is so much more thorough to give a complete washing or dusting this way.

45. Unless the floor upon which the piece of furniture stands is protected, the worker will subconsciously slight the job at hand (or go to the other extreme and splash all over the place). In the effort to spare the floor a few drops of water, too little water will be used to do a consistent cleaning job.

It is therefore much simpler to take an extra moment to drape a protective drop cloth on the floor around the article and to thus facilitate the cleaning job.

46. It is disconcerting to most people to have small articles placed hodgepodge upon a night table, dresser or desk. They grow accustomed to having each small article in a certain handy place where they can reach for it and find it easily. It is also neater to have a specified place for each article.

Dusty advises that you should study the location of each article before removing it for dusting. Make a mental note of exactly where it belongs. When you are finished with the cleaning and dusting of the large surface, remember to replace the small items in the exact location you took them from. This is a very good habit to develop.

Constant Attention



Constant attention is the essence of fine hospital service: in supplying every need of the patient . . . in watching every detail of maintenance and management . . . in demanding highest quality and greatest value when purchasing materials and equipment.

Constant attention must be given, for example, to the selection and maintenance of an adequate stock of sheets and pillow cases. That's why so many experienced hospital purchasing agents prefer UTICA Muslin sheets, woven with over 140 threads to the square inch (finished count). UTICA Muslins provide comfort and good appearance through long wear and many launderings.

UTICA Muslins are manufactured with constant attention to the most rigid standards of quality. They are made in one of the most modern mills of its kind in the world—to satisfy your standards of quality at the lowest possible cost to you.

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Planning the Nurses' Residence

(*Continued From Page 70*)

for educational and residence units divide respective areas by the major purposes they serve.

AREAS OF EDUCATIONAL UNIT
- Administration, management and faculty headquarters
  - Offices
  - Conference rooms
  - Duplicating and workrooms
  - Storage
  - Public facilities
- Teaching
  - Classrooms
    - Lecture
    - Seminar
    - Demonstration
    - Laboratory
  - Library
  - Auditorium
  - Storage
- Personnel facilities
  - Restrooms, dressing rooms, lockers, closets
  - Dining facilities
- Maintenance and housekeeping
  - Workrooms
  - Storerooms
  - Receiving and distributing rooms

AREAS OF RESIDENCE UNIT
- Student living quarters
  - Bedrooms
  - Lounges and kitchenette
  - Bathrooms, toilet facilities
  - Storage
  - Laundry and pressing room
  - Sewing room
  - Recreational library
  - Guest rooms
- Reception, recreation and social areas
  - Residence lobby and office facilities
  - Public facilities
  - Main lounge
  - Parlors
  - Serving pantries
  - Recreation room
- General health and welfare
  - Health units
  - Dining facilities
  - Chapel
- Maintenance and housekeeping
  - Workrooms
  - Storage rooms
  - Receiving and distributing rooms
- Employe convenience
  - Restrooms
  - Dressing rooms

Final selection of areas and rooms is, of course, dependent upon evidence of need for them. One school will require many accommodations; another may need only a few because of the circumscribed functions it serves in a total program.

Step 3—Preparing the written recommendations. The mere listing of areas is not sufficient to assure a good plan. The preparation of written recommendations brings the rationale of needs from Step 1 into their relationship with area potentials of Step 2. This becomes the written program from which the architect can develop the plan for a facility in terms of needs as described by the consultant.

Just what goes into this report? It should specify every room or area required. For each such area there should be supporting comments relative to: (1) purpose of the room, unit or area and the activities to be performed in it; (2) number and type of individuals or groups to be accommodated, intervals of use, seasonal and daily load; (3) special features required, inherent hazards; (4) equipment and supply to be used or stored in unit, and effect on size, shape or arrangement of room; (5) interdependence and necessary physical relationship with other units, and (6) total number of these units needed.

A flow chart of supplies, activities and people is useful. To illustrate further, a sample worksheet, "Physical Facility Needs for Office of Educational Director," is shown in tabular form. (See page 70.)

The report need not take this specific form. Different areas will require varying emphasis and elaboration of different points, depending upon their importance to the educational program. The importance, however, of submitting a written program cannot be overemphasized. Recommendations cannot be given orally with good effect. A written program based upon needs for educational and welfare purposes, when incorporated with similar work from other competencies, constitutes the essential guide to blueprints and so to the building itself.

A written program serves many purposes. It describes the aim, scope, activities and special features of the programs to be centered in the building. It describes what is required of the facility in order to perform future functions in an orderly and effective manner. It is the basis for functional architectural design and planning. It describes common goals and needs in a common source of information, and thus avoids misunderstandings. The preparation of a written statement, requiring careful thought to detail, helps classify thinking before construction is begun. It provides a basis for development of equipment lists. It is one of the source references for estimating costs.

The consultant should be guided in her recommendations by current regulations, standards and criteria as set forth by the state authority for approval of nursing education as well as by the national nursing organizations.

Step 4—Obtaining administrative acceptance of the recommendations. Every effort should be made in advance to coordinate the recommendations of all related advisers and departments. Once accepted, the architect can begin to translate the stated requirements into a plan, the blueprint for truly functional facilities.

Step 5—Follow-through. This requires that the consultants and committees be available for continued consultation with the architect and others. As blueprints are developed there may be need for further explanation, compromise, adjustment or even major changes from the original plan. If modifications of any sort are in order, they should be made, for economic reasons, before the adoption of final blueprints. For practical purposes, changes should be considered impossible after construction is under way because of cost. However, late discoveries of gross inadequacies must be given due consideration.

In summary: Because no two situations are identical in scope and purpose, planning must be done individually in order fully to meet specific needs. Time and expense can be saved and a more functional unit produced when proper programming is done early. Not only must planning be done early but ample time must be given to it. Little can be accomplished in a day or by "off-the-cuff" recommendations.

Programming is affected by the characteristics, scope and purposes of service to be rendered; it should seek to meet needs realistically; it should be guided by economy of construction and economy in operation. A functional facility can best be realized from a carefully prepared written program.

[1]Grateful acknowledgement is made to the staff of the National League for Nursing for its cooperation, review and suggestions in the development of this guide. The author is particularly grateful to many of her associates in the U.S. Public Health Service for their review and valuable suggestions, and with whose encouragement and support the organization of this material was made possible. Technical and professional guidance and suggestions were given by several staff members in the Division of Medical and Hospital Resources, Division of Hospital Facilities, Division of Hospitals, and Division of Nursing Resources.



Clinton Memorial Hospital
Wilmington, Ohio
Architect: Marlay W. Lethly
Contractor: Sever Williams

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Carrier air conditioning refrigeration industrial heating

BENJAMIN RUSH

(Continued From Page 88)

Upon the Diseases of the Mind." 1812.

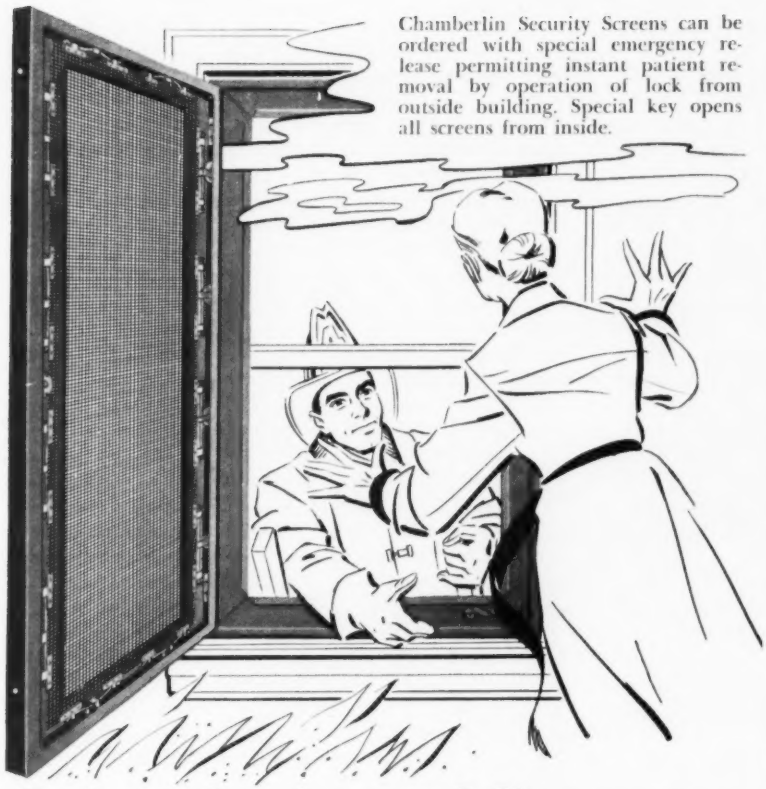
It is said of him that he had his failings, yet "had he lived in the days of heathen philosophy, he would have been deified for his virtues, and his monument would have honored some conspicuous niche in a heathen temple."[7] Because of the value of his historical account of yellow fever and as a mark of respect for all his writings and his fine character, he received a medal from the king of Prussia, a gold medal from the queen of Etruria, a costly diamond ring from the emperor of Russia and personal thanks from the king of Spain. Two medals were struck in his honor at the United States mint. The American Medical Association erected a monument to him in Washington in 1904. Dr. Wilson said at that event, "As a physician and philanthropist Dr. Rush occupied during his life the central place on the stage of American medicine. . . . We cannot measure his practice by ours; old things have passed away and all things have become new. But we must grant him the courage of his convictions. . . . He was the first great American physician."[12]

The notebooks left to his children reveal much of the man. "No one who reads these extraordinary books can ever again classify Benjamin Rush in one sentence, or say simply that he was a great man. He was great and he was a man, with all the complexity and imperfection of a struggling human soul."[1]

It must have been in the sweet, earnest solemnity that Rush used to address his devoted students that he wrote:

"It is not to him that willeth, nor to him that runneth, but to the overruling hand of Heaven alone that we are to look for the successful issue of all human actions whether of body or mind. Humble and unworthy instruments are often employed in promoting the physical as well as moral happiness of mankind in order to confound the splendor of those external circumstances which attract and fix the esteem of the world."

For bibliographic notes, see list on page 87 of the September issue of The Modern Hospital.



Chamberlin Security Screens can be ordered with special emergency release permitting instant patient removal by operation of lock from outside building. Special key opens all screens from inside.

Reduce the threat of disaster, too, with Chamberlin Security Screens

You reduce the threat of disaster. No grilles, no bars to trap patients in case of fire. No stubborn or jammed locks to hinder rescue operations. Exclusive Chamberlin locks permit *instant* patient removal from outside in emergencies.

You reduce glass breakage. Inside mounting of Chamberlin Security Screens reduces window-glass breakage, cost of glass replacement, patient injury.

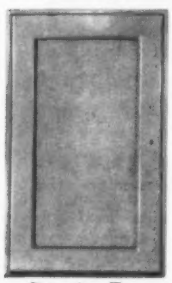
You reduce sash repair and paint costs. Chamberlin Security Screens mounted at recommended distances from window help prevent mutilation of window frames, sash, paint.

You reduce grounds maintenance costs. Patients can't throw litter out of window, can't store it on window sill, can't receive forbidden objects.

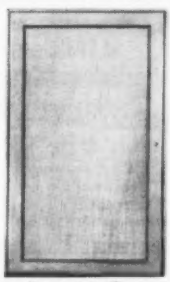
You eliminate insect screen costs. Close-woven, high-tensile-strength wire of Chamberlin Security Screens takes place of insect screening, withstands usual abuse. Admits ample light and air.

Over the years, these savings will more than offset your original screen costs. Yet they're only a few of the savings and services other hospital administrators receive every day (see right). Let our Hospital Advisory Service give you full details. Write today.

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QUICK NOTES

on savings and services provided by Chamberlin Security Screens

In the last fourteen years, over 80,000 Chamberlin Security Screens have provided these and additional savings and services to hundreds of hospitals in almost every state of the U.S. and in numerous foreign countries.

Chamberlin Security Screens reduce maintenance time, effect material savings: Replace heavy bars and guards. Replace insect screens. Stop glass breakage and damage to window frames and sash. Reduce painting requirements. Reduce grounds maintenance work by keeping litter in rooms.

They reduce cost of medical care for physical injury: Prevent self-damage and attacks on attendants with broken glass. Prevent cold-inducing drafts. Prevent suicide attempts by hanging from window muntins, grilles, bars. Prevent receipt of dangerous pass-in objects.

They provide more cheerful atmosphere. Supplant depressing jail-like bars and grilles. Make room interior more homelike; keep building's exterior uncluttered. Admit ample light and summer air.

Chamberlin Security Screens *supplement* supervision. Special Chamberlin locking device resists tampering and plugging attempts. Close-woven, high-tensile-strength wire mesh foils usual picking and prying. Smooth frame edges and rounded corners preclude accidental or intentional self-damage. Screens can be provided with emergency release permitting instant patient removal by operation of lock from outside.

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We Tried the Inventory—and It Works!

(Continued From Page 87)

in three months because he isn't interested. I go through the same thing three or four times a year. Now if I spend a little more time with orderly No. 1, really tell him about the things he'd probably like and deserves to know, show a continued interest in how he's doing, maybe I can hold him on the job. If so, I'll sure save myself a lot of time by cutting out future indoctrinations. The office will save time in interviews, records and pay-roll changes. I think this will actually make our jobs easier. *(General nodding agreement.)*

There it is! They had sold themselves!

LEADER: All right. But here you've decided on something you want to do. You're going to barge right ahead on your own. Haven't you pretty much set up a new policy and procedure? Isn't that a matter of administrative initiative?

MEMBER F: Oh, this has happened before. When we work out something that makes sense, Administration has gone along with us. Of course, we were a little hasty. The administrator will have to approve it.

MEMBER T: That's O.K. Suppose when the minutes of this meeting are written up, Miss F takes them to the administrator for approval. Then we'll get the green light by memo or at the next staff meeting.

LEADER: What about the other new conference group? Perhaps it will feel you are taking a lot for granted. That you are telling them what to do.

MEMBER F: Why don't Mrs. G, Miss P and I attend its meeting, discuss the subject and show how we worked this out. See that that group's thinking parallels ours. Then there won't be any feeling about our having steamrollered anything. *(Persons mentioned are all trained conference leaders. Unanimous agreement on this procedure.)*

So what has happened? Administration wanted to institute an orientation program. The need was introduced to the conference group as part of an unfavorable attitude situation uncovered by the Employe Inventory. The group used problem solving technics and came up with an answer —a policy, a method. These were not imposed on them by administrative edict. They figured it out for themselves. Laborious and time consuming, you say? Perhaps. But people will follow their own ideas much more enthusiastically than they will something imposed upon them. It being their idea, they will be much less critical if jokers develop. They will want the plan to work and will work to make it succeed.

Here we have a beautiful case history of what can be done through the conference method. But it should be pointed out that the stage was all set for such cooperative effort. For a couple of years these folk have been working in a planned atmosphere of emotional security. They have been used to intimate participation in matters of planning, policy and practices. They are partners in consultive supervision. They have had evidence that, as they are ready, they will be given responsibility and independence. The "impelling leadership" of administration has stimulated subordinates to think and plan for themselves. These things do not just happen. But they can happen if your human organization is in gear.

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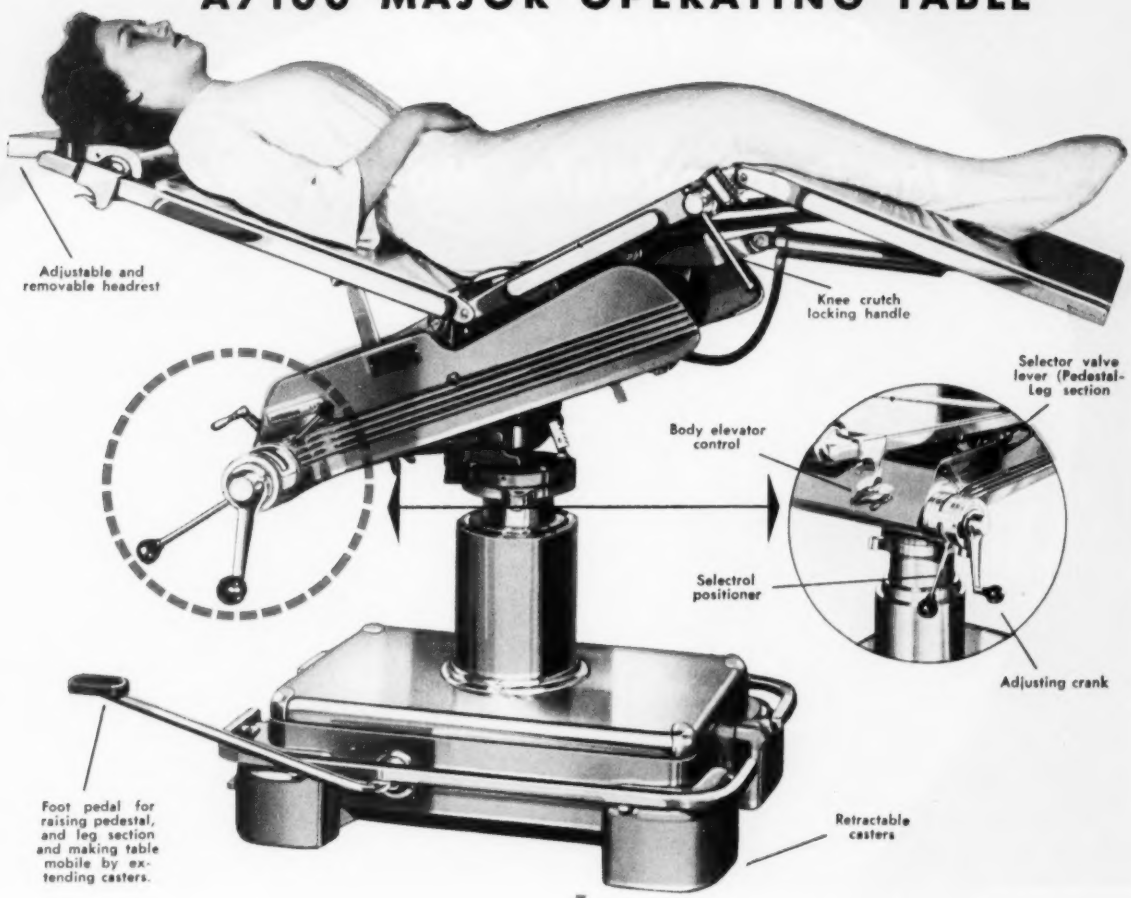
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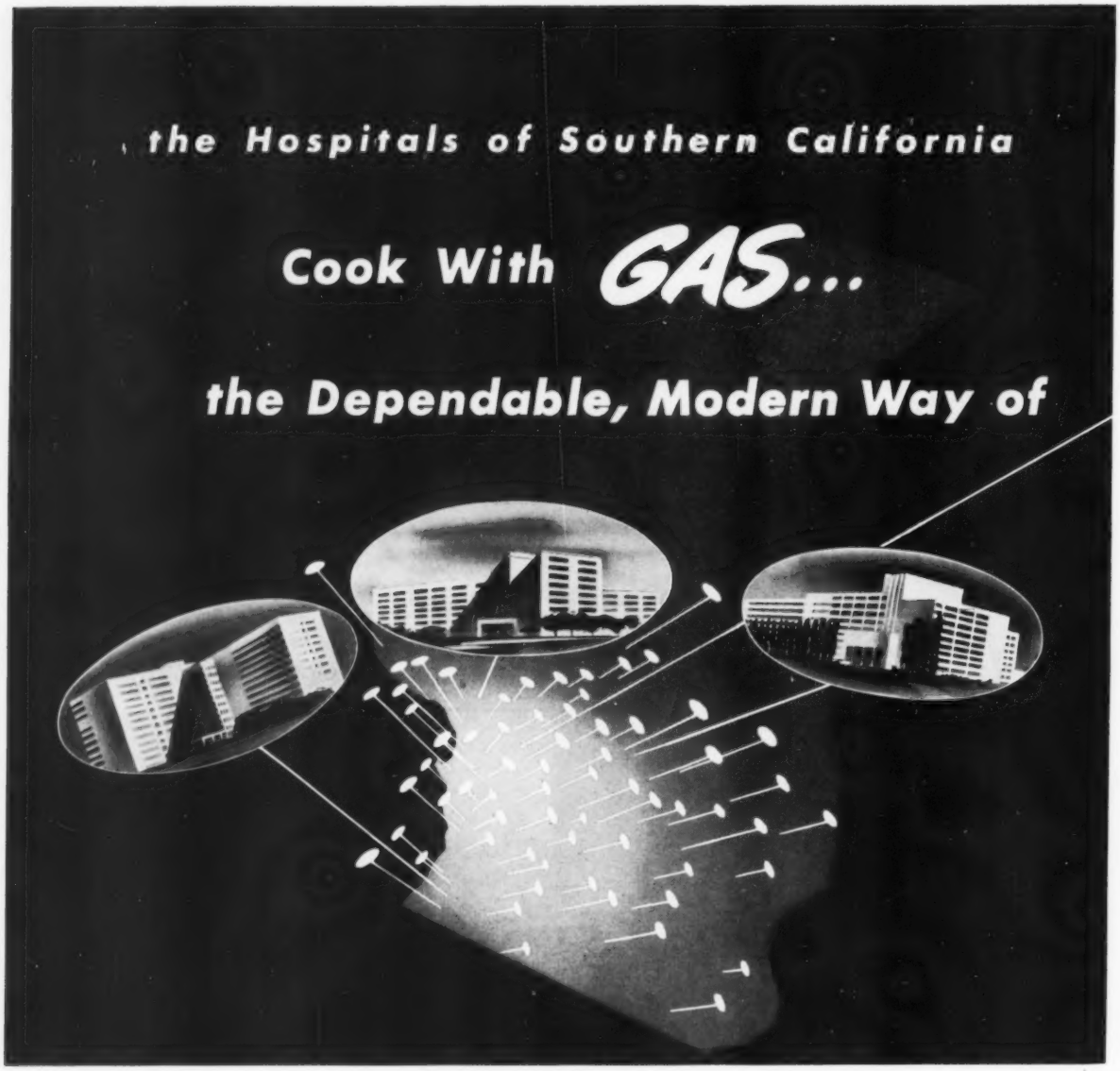
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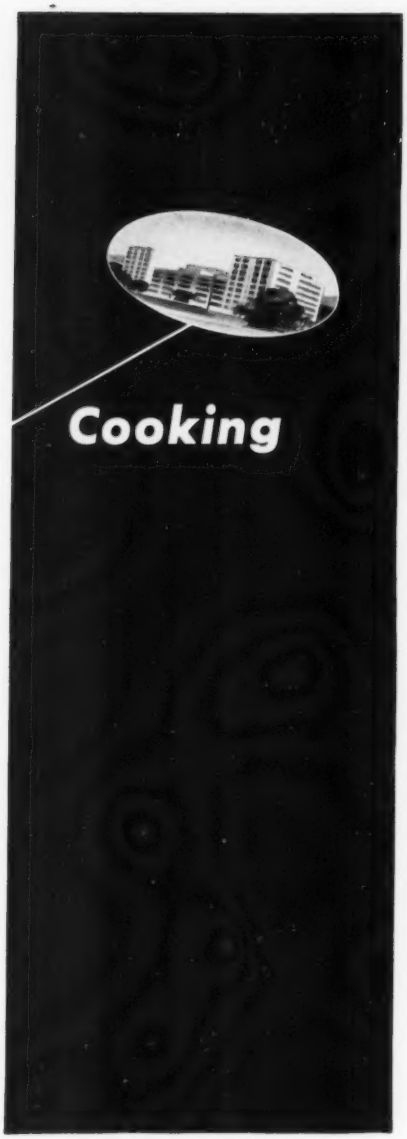
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87 HOSPITALS

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NEWS DIGEST

A.H.A. Convention Report . . . Army Has Too Many Doctors, A.M.A. Charges . . . P.H.S. Reports Shortage of Beds in Eight-State Area. . . Three Nebraska Hospitals Improve Facilities . . . Health Committee Lists Ways to Meet Personnel Shortage

A.H.A. Convention Report

(*Continued from Page* 71)

changed shop talk while they gazed at Alcatraz and the Golden Gate Bridge.

This year's program ran heavily to panel discussions, and, in the opinion of some observers, the panels sometimes ran away with the program as moderators struggled to keep the discussion in focus and still give each of a dozen or more panelists his moment in the sun. First names fell like hailstones in these sessions as participants who never saw each other before knocked themselves out calling one another "Bob" and "Joe," in obedience to the peculiar custom of panels.

Featured on several of the programs were representatives of industry and universities — management experts whose helpfulness at solving hospital problems had been proved in smaller conferences but did not always emerge clearly in the inevitable confusion of large meetings encumbered with television lights, cameras and operatives. Most of the programs, as a matter of fact, were smoother and easier to follow on the television sets installed in upstairs corridors than from the audience; as a new A.H.A. service, the filmed programs will be available to member hospitals for local and regional meetings, it was announced.

In official sessions, the association's house of delegates approved a new statement on hospital-physician relations that had been worked out by a joint committee of the boards of trustees of the A.H.A. and the American Medical Association and endorsed by the A.M.A.'s house of delegates last June, and okayed a National League for Nursing proposal for reorganization of the acreditation program for nursing schools, giving the A.H.A. five representatives on the 17 member executive committee that will direct the program.

Both actions were taken after considerable discussion. Opposition to the statement on hospital-physician relations was based on its inclusion of doctor-members on hospital boards as one of several acceptable methods of bringing staff and board together; opponents of the accreditation program took the view that it might wreak harm, if not disaster, on small diploma schools. After protracted debate, however, both proposals received overwhelming support among the delegates when the votes were counted.

At the association banquet on the final night of the convention, new president Ritz Heerman, took office, with appropriate ceremony, from retiring president Edwin L. Crosby, while president-elect Frank R. Bradley of St. Louis, named to office the previous evening, looked on. Dr. Basil C. MacLean of Rochester, N.Y., received the association's award of merit for 1953, and Dr. James M. Mackintosh of the London School of Hygiene and Tropical Medicine, accepting honorary membership, urged America's hospitals to remember their rightful rôle as merciful healers rather than simply big businesses.

The hospital can never fulfill its true function in society by waiting for the sick and injured to be brought to it for treatment, Dr. Mackintosh warned. Instead, it must take the initiative as a leader in health protection and preventive medicine for the whole community. On that forward-looking note, the 55th annual convention closed.

AUXILIARIES

The handsome hero of "Kiss Me Kate" sings a baldfaced number: "I've Come to Wive It Wealthily in Padua." Dr. Philip D. Bonnet of Boston in a Tuesday talk maintained that the American hospital, having been dehumanized and depersonalized by men, had been forced to take a wife, namely, the women's auxiliary.

That the hospital has managed to "wive it wealthily" was never better demonstrated than at the auxiliaries' sixth annual conference, where by common consent the speakers proclaimed that the wealth the wife brings is first of all educational and spiritual and only secondarily—and as a by-product —financial.

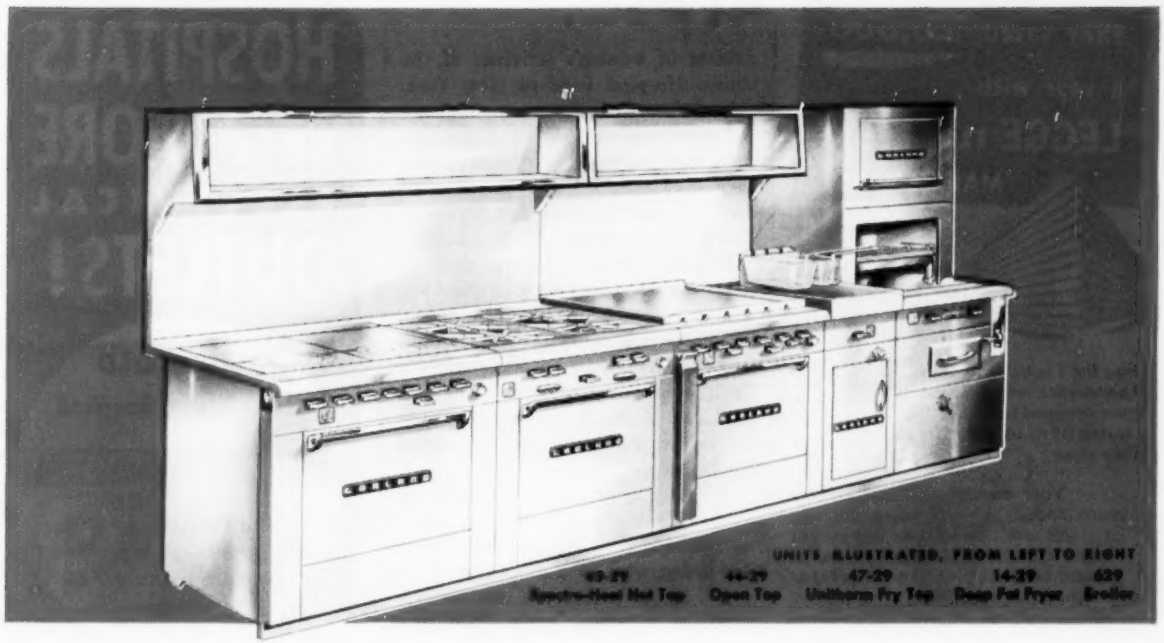
The women's auxiliary conference came to the West but the West didn't come to the conference—in any appreciable numbers. But those who attended, regardless of speedometer record, were eager to share, hungry to learn, and delightful to look at.

"The Best Dressed Woman of the Year Is the Hospital Volunteer" was the hit song of the Boston Beth Israel show last winter, Mrs. A. E. Pinanski related in one of the better talks of the conference, and although the 1953 delegates were out of uniform they were in high style from the hats on their heads to the shoes off their feet. (Speeches were better with the shoes off.)

Of evening the hospital administrators were largely on their own, which meant on the town. Not so the working wives (auxilians)! Each night at the St. Francis the women gathered in groups to swap stunts, services and success stories. The hospitals will have wived it wealthier when the gals get home.

"You must see yourselves as service groups, never as pressure groups," Raymond P. Sloan of The MODERN HOSPITAL warned the delegates, urging them to deal only with intelligently acquired facts in interpreting the hospital to the community.

Among those who demanded an ex-officio place on the hospital board of trustees for the president of the deserving auxiliary was Olive Andrews,



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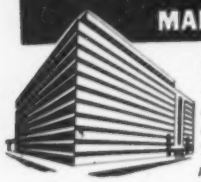
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NEWS...

director of women's activities of the United Hospital Fund of New York.

Under an active national committee and the secretaryship of Elizabeth Sanborn, half of the 1700 hospitals that have auxiliaries are now members of the American Hospital Association in its Type V category.

Dr. Madison B. Brown now of Roosevelt Hospital, New York City, soon to be of Hahnemann Hospital in Philadelphia, explained to the auxilians why "high quality medical care is Cadillac in price." And to make hospital care worth its price, integrity is needed in every aspect of hospital service, he declared.

To the guy who says "I'd rather go to the Waldorf" when told that hospital costs per patient vary from $19 to $33 a day, what's the proper retort?

Dr. Brown took some time to help auxiliary members reply to such a scoffer.

"Hospital rates aren't high," Dr. Brown explained; "they only seem high. The per diem cost at Roosevelt Hospital is $21.86 a day. What the gentleman would not get at the Waldorf is three meals a day, the services of an intern, a resident, nurses, social service worker, and a number of stand-by services that a hospital must maintain but that not every patient receives. Among these are ambulance service, emergency department, and psychiatric services, all of which are expensive."

The cost of hospital service varies with the size of the hospital and its increasing specialized services and staff, with the type of control (public, private or voluntary), and with the type of institution, whether it gives short-term or long-term care, Dr. Brown told his audience. Then he threw in a corner-of-the-mouth remark that, although our mental disease hospitals have the lowest per diem cost, they should have the highest.

Hospital costs are rising greatly in excess of the inflationary trend, he declared, because of the impact of science and medicine on diagnosis and treatment. More laboratory tests are performed, more x-ray film is used, more diversified services are provided. All of this means more personnel. In his hospital more than two persons are employed for every bed. And the work week is now shorter.

In Roosevelt Hospital, 68 per cent of the budget goes to pay roll. In preparation for a pension plan, this hospital

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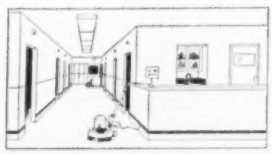
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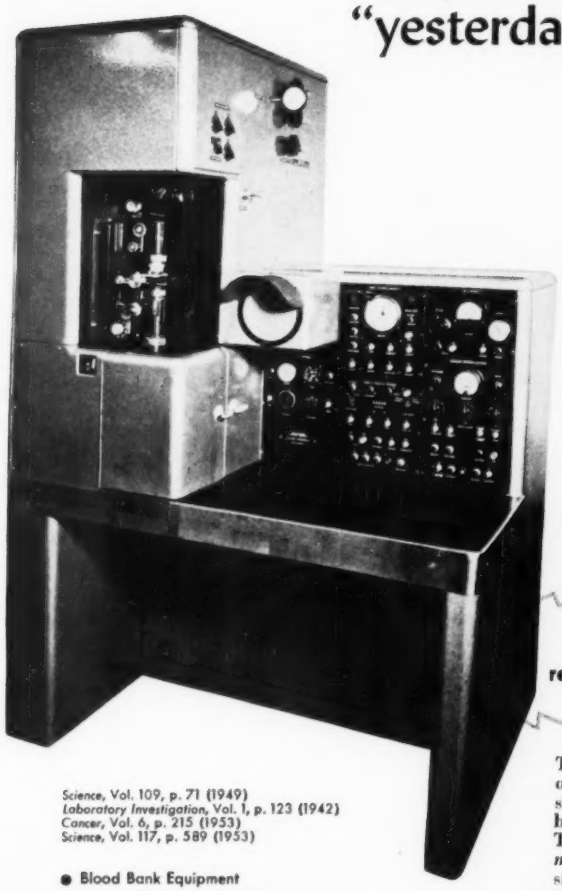


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Science, Vol. 117, p. 589 (1953)

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Mr. August L. Volk, *Manager, Contract Dept., North Star Woolen Mill Co., New York 17, N. Y.*, says, "We understand that the exposition committee has an exceptional program planned this year. To us this means a big attendance by bona fide buyers in all institutional fields. That's why we've signed up for the 38th National Hotel Exposition."



Mr. James H. McCabe, *Vice President, West Coast Operations, Hotels Statler Company, Inc.*, says, "This once-a-year meeting of hotelmen from all over the country serves as a clearing house for the exchange of ideas in methods of operation and promotion. This in itself makes attendance almost mandatory for every alert operator."



Mr. Morton Diamond, *Sales Manager of the Restaurant Equipment Div., The Silex Corp., Hartford, Conn.*, says, "What have I got to say about the coming show? My mind was made up on November 14th, 1952, when we added up our total sales at the close of last year's Exposition. We'll be back for sure!"

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NEWS...

found that it had a high percentage of better paid workers. Among 950 employes there were 58 who earned more than $5000 a year.

"Empty beds are expensive and account for high costs, particularly in old hospital plants," Dr. Brown asserted. It takes the same sized staff to serve 70 per cent occupancy as an 85 per cent occupancy. New hospital design is making it possible to care for high occupancy and thus give the best service at the least cost.

"Tell your critic that there are no bargain sales to offset the summer slump in hospital business as there are in merchandising. No bargains are possible in medical service. The average patient thinks only of the subjective aspects of his hospital care; he fails to consider the 'science' of his care, which is the real factor in the service provided him.

"In 1952 our patients paid an average of $20.37 a day; the cost per hour was 85 cents. It cost the hospital $21.86 to provide them with this care, or 91 cents an hour. Where for 91 cents could you buy so much medical science, safety and happiness today as in the modern hospital?"

W.H.A. AWARDS

The W.H.A.'s sixth birthday luncheon at the close of the conference was gay with thousands of red carnations from one of the local hostess auxiliaries, St. Luke's; dramatic with the nurse recruitment skit, "Dear Mr. Postmaster," the cast drawn from the Actors' Workshop of the San Francisco Drama Guild, and rewarding with the presentation of citation awards to winners in the 1953 "Know Your Hospital Through the Hospital Auxiliary" contests.

Maj. Gen. George E. Armstrong, surgeon-general of the army, gracefully presented citations to representatives of the following hospital auxiliaries:

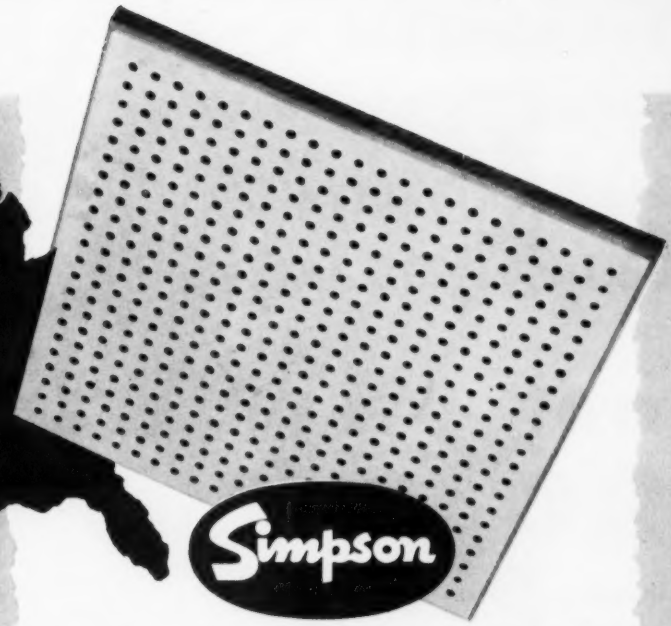
Baptist Hospital Ladies' Auxiliary, Alexandria, La.; Newton-Wellesley Hospital Aid Association, Newton Lower Falls, Mass., and Baroness Erlanger Hospital and T. C. Thompson Children's Hospital, Chattanooga, Tenn. Three hospital auxilaries in Grand Rapids, Mich., received a special citation award for a joint project for National Hospital Week.

President Edwin L. Crosby of the A.H.A. attended the luncheon and told the auxiliaries that their workers in

SIMPSON CERTIFIED ACOUSTICAL CONTRACTORS
USING GENUINE Simpson ACOUSTICAL PRODUCTS

ALABAMA
Badham Insulation Co., Inc., Birmingham
Stokes Interiors, Inc., Mobile
ARIZONA
Fiberglas Engineering & Supply Co., Phoenix
Hall Insulation & Tile Co., Tucson
ARKANSAS
National Builders' Supply, Inc., Little Rock
CALIFORNIA
Coast Insulating Products, Los Angeles and San Diego
Cramer Acoustics, San Francisco and Fresno
COLORADO
Construction Specialties Co., Denver
CONNECTICUT
W. T. Roberts Construction Co., East Hartford
DISTRICT OF COLUMBIA
Kane Acoustical Co., Washington
GEORGIA
Jumas and Searl, Inc., Atlanta
ILLINOIS
General Acoustics Co., Chicago
INDIANA
The Baldus Co., Inc., Fort Wayne
E. F. Marburger & Son, Inc., Indianapolis
IOWA
Kelley Asbestos Products Co., Sioux City
KANSAS
Kelley Asbestos Products Co., Wichita
KENTUCKY
Atlas Plaster & Supply Co., Louisville
MARYLAND
Lloyd E. Mitchell, Inc., Baltimore
MASSACHUSETTS
W. T. Roberts Construction Co., Cambridge
MINNESOTA
Dale Tile Company, Minneapolis
MISSISSIPPI
Stokes Interiors, Inc., Jackson
MISSOURI
Kelley Asbestos Products Co., Kansas City
Hamilton Company, Inc., St. Louis
NEBRASKA
Kelley Asbestos Products Co., Omaha
NEW JERSEY
Kane Acoustical Co., Fairview
NEW MEXICO
Fiberglas Engineering & Supply Co., Albuquerque
NEW YORK
Robert J. Harder, Inc., Lynbrook, L. I.
James A. Phillips, Inc., New York
Davis-Fetch & Co., Inc., Buffalo, Rochester and Jamestown
Davis Acoustical Corp., Albany
NORTH CAROLINA
Bost Building Equipment Co., Charlotte
OHIO
The Mid-West Acoustical & Supply Co., Cleveland, Akron, Columbus, Dayton, Springfield and Toledo
OKLAHOMA
Harold C. Parker & Co., Inc., Oklahoma City
Kelley Asbestos Products Co., Tulsa
OREGON
Acoustics Northwest, Inc., Portland
R. L. Elfstrom Co., Salem
PENNSYLVANIA
General Interiors Corporation, Pittsburgh
Jones Sound Conditioning, Inc., Ardmore
TENNESSEE
John Beretta Tile Co., Inc., Knoxville
John A. Denie's Sons Co., Memphis
The Workman Co., Inc., Nashville
TEXAS
Blue Diamond Company, Dallas
Fiberglas Engineering & Supply Co., El Paso
Otis Massey Co., Ltd., Houston
Builder's Service Co., Fort Worth
UTAH
Utah Pioneer Corporation, Salt Lake City
VIRGINIA
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Elliott Bay Lumber Co., Seattle
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Building Service, Inc., Milwaukee
CANADA
Albion Lumber & Millwork Co., Ltd. Vancouver, B. C.
Hancock Lumber Limited, Edmonton, Alberta

52 *reasons why* Simpson acoustical installations are superior



Simpson certifies the quality of its products and its contractors

The 52 firms listed at the left are Simpson Certified Acoustical Contractors, leaders in the field of acoustical engineering and installation . . . selected by Simpson and *certified* to be reliable, efficient and ethical. To maintain their high standards, these contractors are kept constantly abreast of new developments in the field of noise control by frequent contact with Simpson's acoustical experts and their fellow Certified Contractors.

Using genuine Simpson acoustical materials . . . unsurpassed in efficiency and appearance . . . these contractors offer you superior acoustical installations, because of superior materials and superior workmanship.

These Simpson Certified Acoustical Contractors have the equipment, experience and craftsmen necessary to insure an efficient and attractive acoustical installation in structures of any type, to your exact specification. For consultation and estimates, call the SCAC member nearest you.



ACA-C35

Operating Room, Truett Memorial Hospital, Dallas, Texas. Architects, Thomas, Jameson and Merrill. General Contractor, Inge-Hayman Construction Company. Simpson Certified Acoustical Contractor, Blue Diamond Company, Dallas.

ACOUSTICAL TILE ...HOLLOKORE DRILLED

This efficient, perforated woodfiber acoustical tile . . . made to exacting specifications by Simpson, one of the largest and oldest forest products organizations in the Pacific Northwest . . . has *six features of superiority:*

HOLLOKORE DRILLED PERFORATIONS. Simpson-developed *hollow* drills make clean holes, without fuzzy edges or burrs to collect dirt or encourage "bridging" when repainting.

WASHABLE FINISH. Simpson's bright-white finish is readily cleaned with soap and a damp cloth, and may be repainted repeatedly without loss of efficiency.

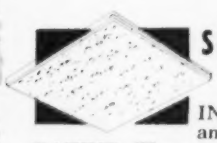
PAINTED BEVELS—finished in the same light-reflecting white.

HIGH SOUND ABSORPTION—unexcelled by any similar material.

THERMAL INSULATION. Millions of tiny air cells, in and between the fibers, provide effective thermal insulation.

BIOTOX PROTECTED, by a *safe* chemical process, against mold, mildew, termites, decay and dry rot.

NOW also available with *Scatter-Drilled* perforations, minimizing the mechanical pattern of the holes.



SIMPSON FISSURED TILE

A MINERAL ACOUSTICAL MATERIAL

INCOMBUSTIBLE: Solid rock, melted and re-formed into mineral fiber. DECORATIVE: The *natural* fissures differ on every tile, and provide an interesting ceiling texture. PERMANENT: Cannot decay or deteriorate, easily cleaned with a vacuum cleaner, and may be repainted repeatedly without loss of acoustical effectiveness. EFFICIENT: The sound absorption coefficients of these attractive tiles are remarkably high, and the special finish has excellent light-reflecting qualities.

Available in beveled or square edge units

OTHER SIMPSON ACOUSTICAL PRODUCTS

METAL ACOUSTICAL UNITS ★ PERFORATED HARDBOARD

PERFORATED CEMENT ASBESTOS BOARD

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ACOUSTICAL MATERIALS ★ ALLWOOD HARDBOARD ★ INSULATING BOARD PRODUCTS ★ PLYWOOD ★ DOORS ★ CALIFORNIA REDWOOD ★ FIR AND WEST COAST HEMLOCK LUMBER



"Is there any *easier* way to enlarge an operating room?"

"Not that we know of," says John R. Stone, Administrator of Henry W. Putnam Memorial Hospital, Bennington, Vt.

"We used 'Modernfold' doors to replace old-fashioned swinging doors on our minor operating suite."

"Result: a bigger room . . . easier to work in. Our doctors now use it all the time—not just during emergencies."



LOOK FOR THE FOLDING DOOR WITH THE DOUBLE-STRENGTH FRAME

It's the extra steel in "Modernfold's" sturdy frame, with double hinge plates both top *and* bottom, that make "Modernfold" the most durable, dependable, easy acting folding door on the market today. Finest obtainable vinyl fabric covering washes clean with plain soap and water —practically the only maintenance needed with long-lasting "Modernfold" doors.

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NEWS...

the hospital now number more than a million and, in fact, equal or surpass the number of paid employes of American hospitals.

INTERNALIZING

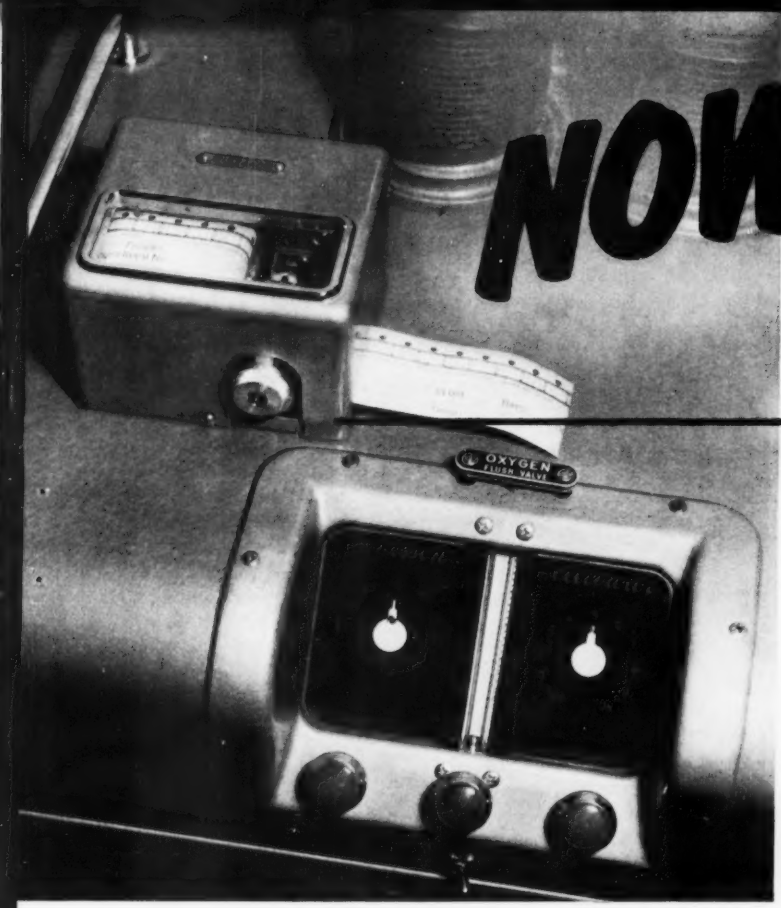
Suppose, as a boss, you don't want to be a stinker. You want to be a good boss. You want to "internalize" the good human relationships you learned about out of a book or out of an A.H.A. general session. How do you proceed?

Elongated old Polk Hall was packed with people Thursday morning eager to learn from speaker, film and specialists' panel how to do the right thing by the fellows under them and even the fellows above them.

Jovial Robert D. Gray had come up from Cal-Tech in Pasadena to explain what makes a person tick. A G.E. film was shown to explain what will make an employe tick for the organization, and some very fine vice presidents from industry and representatives from hospitals "tocked the tick idea" around for two solid hours of the clock.

The right pitch is to look at things from the point of view of the employe who is not working out and also from the point of view of other employes who are working out. Maybe you made a poor choice in hiring. Maybe your marvelous orientation program slipped up and the laggard was inadequately inducted. Maybe you or your supervisor were too busy that day or week or month to give him the training your training program called for. Maybe outside problems are troubling the employe and he hesitates to open up to you or the supervisor lest one of you blab his personal affairs all over the place. Maybe he would work out in some other department (only, please don't pass the lemon). At any rate don't forget his co-workers' complaint: "We all take a licking when a deadhead gets in."

Now as regards "internalizing," the one $25 word of the whole session—and, mark you, these were specialists with voluminous vocabularies—the main approach is to be mature enough not to expect employes to be perfect, or even superiors to be perfect. Next you enter into a long-range program of letting them—department heads, supervisors, employes, in groups—know about the purposes and problems of business, the department, or the task. (*Continued on Page* 156)



A NEW INSTRUMENT THAT RECORDS HOW LONG AN OXYGEN TENT HAS BEEN IN USE

THE McKesson TYMOLOR

The only instrument invented that keeps permanent unchangeable records which are forwarded to accounting with patients' charts.

SEE HOW EASY IT IS TO OPERATE . . .

Nurse rolls strip with Hand Knob to proper place . . . She fills in data (patient's name, room number, flow rate, date and starting time) . . . She turns on master switch which automatically starts Tymolor operating . . . Finally, when switch is turned off, a simple push and turn enables her to roll tape out, tear off and attach to patient's chart—the permanent unchangeable record has been made—*perfect proof of service!*

FOR THE FIRST TIME—

YOU CAN GET AUTOMATIC PROOF OF OXYGEN-TENT SERVICE! HERE'S HOW—



THIS LINE TELLS HOW LONG OXYGEN TENT HAS BEEN USED

Tymolor starts operating automatically when master switch is turned on. Non-ink stylus makes permanent record on self-impression non-eraseable paper . . . With tapes like these, hospitals can *for the first time* establish an efficient method for oxygen-tent charges!

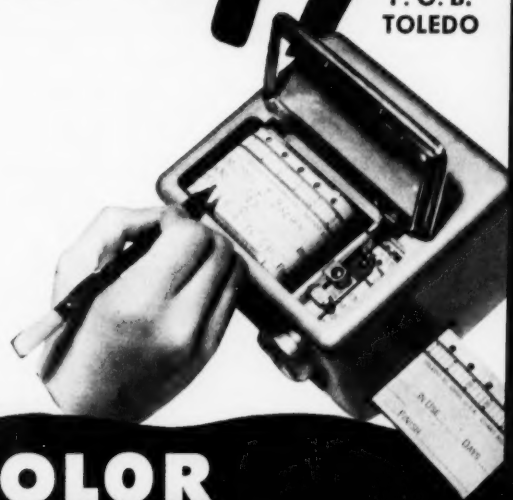
SIMPLE TO INSTALL

Instructions, parts and template for locating position, are provided with every Tymolor. With these, Tymolors (which are powered by Telechron) are easily installed on *any* Oxygen Tent using AC current.

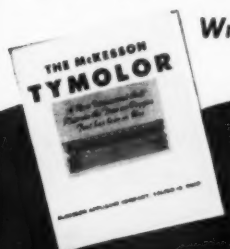
Costs only

$47.50

F. O. B. TOLEDO



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McKesson TYMOLOR

McKESSON APPLIANCE CO., TOLEDO 10, OHIO

Manufacturers of these major products—Bronchio Spirometry, Anesthesia, Resuscitators, Suction Pumps, Matabolism, Oxygen Tents, Analgesia, Vital Capacity, Pneumothorax, Air Compressors, Rocking Beds, Dermal Temperature, Oxygen Therapy

NEWS...

Soon you will find yourself neck deep in group think, only you aren't obliged to call it that. It has been called "consultative management" as opposed to "insultative management."

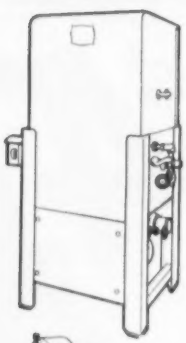
Under this scheme, you call the management group or the supervisors or the workers into conference and you boldly say: "I don't know what to do about this problem. I need your help. Let's kick the thing around and see if we can't work out an answer."

Sure enough, the answers won't be very good—not at first. But do it anyway. You may try out the group solution even if it does not promise to work out—you'll get cooperation on it, that's certain. That way—the group thinking way—you create a climate in which ideas can grow.

Don't begin this delegation of management authority on a large scale. Begin it with small things. Delegate with great discrimination. But take the plan all down the line; don't stop with department heads and supervisors. Get all the way down to the bottom. In fact, improved human relations don't need to start from the top. A grass-roots movement can start any place and spread like fire, uphill, down dale.

That's what the men said on Thursday morning.

You get HIGH QUALITY... Advanced Performance with Universal DISHWASHERS



A dishwashing machine is a substantial investment. To be sure you get the make and model best for your needs, compare Universal quality and performance before you buy.

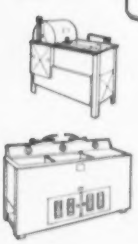
UNIVERSAL DISHWASHING MACHINES OFFER YOU ALL THESE GREAT ADVANTAGES

180° built in Rinse water booster. Saves installation cost.

50% BETTER Dishwashing with "swing-wash" action. Does more work in less time.

HYDRAULIC Time Control of Dishwashing and Rinse Cycle. Insures uniform results with less labor.

31 MODELS. Most complete line with most wanted features.



Write for Complete Catalog TODAY!

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49 WINDSOR PLACE, NUTLEY 10, NEW JERSEY

World's Largest Exclusive Producer of Commercial Type Dish, Glass and Silver Washing Machines

FEDERAL HOSPITALS

"You'd get quicker medical care if you were shot in the Korean battle line than in the heart of an American city," Dr. Melvin A. Casberg, assistant secretary of defense for health and medical affairs, told those who attended the annual federal hospital luncheon on Tuesday. Rapid evacuation is the reason.

The chances are that the medical care might be better as well as quicker, for Dr. Casberg declared that military doctors in Korea have shown a high degree of professional competence, worthy of any university center. The latest technics are used in their life saving efforts.

A new medical problem of the battlefield is the number of mangling wounds of the extremity. This is a much larger problem than formerly, Dr. Casberg said, owing to a peculiar circumstance: the development of the armored vest. The armored vest has saved so many lives that men who previously would have died now survive to become difficult orthopedic problems or amputees.

Medical problems in Korea are global, Dr. Casberg reported. A Belgian stretcher must fit in a French ambulance and an American plane. The physical barriers thus become important, as well as language and racial barriers.

James A. Hamilton, another luncheon speaker, proposed a new mechanism to integrate federal and civilian hospitals. Growing competition between the two for funds, personnel and patients demands a coordinated approach, he declared.

Maj. Gen. George E. Armstrong presented the federal hospital group's annual meritorious citation to Dr. Malcolm T. MacEachern.

NURSE ANESTHETISTS

Well pleased with the year, their organization, and their convention, the American Association of Nurse Anesthetists reelected all their 1952-53 offi-

EASY WAY TO CUT FOOD SERVICE COSTS AND GIVE MENUS NEW APPETITE APPEAL!



HEINZ 51 oz. CHEF SIZE SOUPS

When you standardize on Heinz Condensed Soups, you eliminate the element of chance. You get complete cost control. And patient satisfaction is *assured*, because you serve soups famous for taste the world over.

And here are five other big reasons why so many hospitals and institutions have switched to Heinz . . . preparation charges are cut to a new low, leftover losses are minimized, uniform high quality is established, 14 kinds give menus wide variety, each 51 oz. tin makes 17 delicious 6 oz. servings.



FREE!

Recipe-of-the-Month Service

New service to hospitals and institutions is the Heinz Recipe Of The Month. Each serves 50 persons. Write Food Service Center, H. J. Heinz Co., Pittsburgh, Pa.

Heinz 14 Good-Taste Favorites

- Mushroom
- Bean
- Beef Noodle
- Chicken Noodle
- Cream of Tomato
- Genuine Turtle
- Chicken with Rice
- Clam Chowder
- Cream of Chicken
- Split Pea
- Vegetable
- Cream of Green Pea
- Chicken Consommé
- Vegetarian Vegetable

Ask Your Heinz Man About

HEINZ CONDENSED SOUPS

57

You Know It's Good Because It's Heinz!



WRIGHT RUBBER TILE

The easiest of all floors to maintain

Wright Rubber Tile makes a floor that can be kept clean with a minimum of effort. It is non-porous—its glossy surface actually repels dirt.

Individual tiles are precision made for precision fit, forming no crevices where dirt can accumulate.

By using Wright-On-Top Cove Base at the wall line and at the base of fixtures, cleaning is made easy . . . mops never touch the wall.

Wright Rubber Tile makes a quiet floor, too. Sound is absorbed, footsteps silenced, noise doesn't have a chance.

These advantages—silence and sanitation—make Wright Rubber Tile the ideal floor covering for hospitals. But in addition, it is the longest wearing, most comfortable, most beautiful floor you can get.

Years of service in hundreds of hospitals back up every claim we make. We invite you to compare.

Ask your architect or contractor about Wright Rubber Tile today.

Send for a free sample of this finer floor covering.

WRIGHT MANUFACTURING CO.
5204 Post Oak Rd., Houston 5, Texas

WRIGHT RUBBER TILE

FLOORS OF DISTINCTION

- WRIGHTEX — Soft Rubber Tile
- WRIGHTFLOR — Hard Surface Rubber Tile
- WRIGHT-ON-TOP Compression Cove Base
- WRIGHT VINYL TILE

NEWS...

cers at the San Francisco convention. They are: president, Josephine B. Bunch, Portland, Ore.; first vice president, Minnie V. Haas, Fort Worth, Tex.; second vice president, Lillian G. Baird, Ann Arbor, Mich.; treasurer, Agnes Lange, Chicago.

Miss Louisiana was named winner at the annual stunt night, for her impersonation of a well known professor in the field of anesthesiology, nosing out the Texas delegation, last year's stunt winner.

Some 500 nurse anesthetists attended the convention, at which an imposing program was presented.

ALUMNI

Freeman May of Memphis, Tenn., will head the alumni association of the Northwestern University hospital administration program for the coming year. Other officers for the group are: president-elect, Roy House, Gonzales, Tex.; vice president, Lee Yothers, Grand Rapids, Mich.; secretary-treasurer, Jane Davis, Niles, Mich., and director, Anthony Dickens, Springfield, Ohio. Pledges amounting to $800 were made to the Malcolm T. MacEachern Fund.

Marion J. Wright, R.N., of Harper Hospital, Detroit, is the new president of the Columbia University alumni in hospital administration. Conrad Howan, Herrick Memorial Hospital, Berkeley, Calif., is vice president; Robert E. Heinlein, assistant administrator, North Country Community Hospital, Glen Cove, N. Y., the secretary-treasurer.

Barbara Lee, administrative assistant, Mountainside Hospital, Montclair, N.J., is the new president of the Yale alumni in hospital administration.

H.I.A.

Roger C. Wilde will serve another term as president of the Hospital Industries Association. Other officers elected at the group's annual meeting in San Francisco include: vice president, J. J. Egan, and secretary-treasurer, James G. Dyett. New directors are: Robert B. Little, Harlan Prater, Harris Willets and H. W. Wallerich.

AID AND COMFORT

Deciding that the time has come for members of the American Hospital Association to find out just what they are buying with their dues, the staff of the A.H.A. put its wares on display

Norton Door Closers give her

The helping hand she needs



with special hold-open feature!

Norton Door Closers are ideal for hospitals because:

Parallel Arm Closers eliminate need for brackets . . . give added headroom where necessary.

2-speed regulation for fast or slow closings with separate latch adjustment.

Rack and Pinion design gives uniform, positive checking action at every point . . . prevents "dead centers."

Simple construction means fewer parts . . . less to maintain . . . less to get out of order.

Non-gumming, non-freezing hydraulic fluid permanently lubricates every inside moving part.

Key-Type regulating screw prevents unauthorized tampering.

● No more "doorway snarls" when a Norton Door Closer with Hold-Open Arm is at work . . . just open the door . . . it stays open until the nurse and her passenger or loaded tray are through . . . then, silently, smoothly, the door closes *automatically*.

And, this is just one of the important features of Norton Door Closers: Fusible Link releases at 160°F. and automatically closes door . . . containing the fire and preventing its spread, thus protecting patients and staff 24 hours a day.

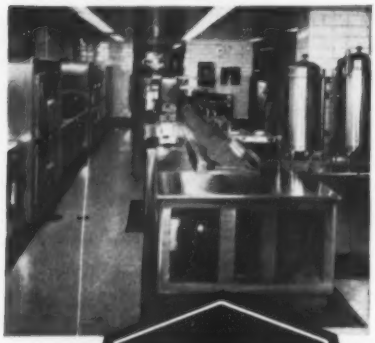
Yes, every desired feature for every hospital need is included with Norton Door Closers. Quality materials assembled by skilled craftsmen result in door closers that will last longer under harder service . . . provide the long range economies so important today. For complete information write: The Norton Door Closer Co., Berrien Springs, Michigan.

NORTON

THE NORTON DOOR CLOSER COMPANY
Division of The Yale & Towne Manufacturing Co.
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Norton Door Closers Are Preferred For Hospitals Everywhere

St. Mary of Nazareth Hospital...



PIX

equipped for better more efficient Dietetic Service



In Chicago's completely modern St. Mary of Nazareth Hospital, new PIX equipment makes kitchen operation easier, provides the finest facilities for preparing the good, nourishing food so important to every patient.

For many years, hospitals and other institutions throughout the country have been discovering how much it means to say "equipped by PIX". For your own kitchen planning and equipment, it pays to remember —"If It's From PIX—It's Right".

IF IT'S FROM PIX IT'S RIGHT

Write Dept. J

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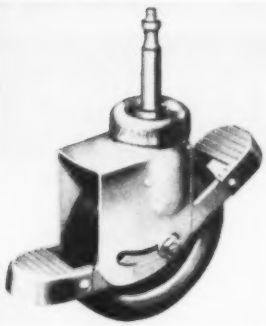
at the Wednesday morning session. These wares—institutes, manuals, handbooks, library service, consultation services, research studies, and general aid and comfort for the harassed administrator and department head—were displayed by a panel of staff members under the guidance of Executive Director George Bugbee. As an administrator, a trustee, a nurse, a dietitian, an engineer, and a purchasing agent, in turn, trotted out a pet problem, the staff member who is particularly qualified in each area suggested the institute, the handbook, or the service offered by the A.H.A. which might provide at least a clue to the solution.

To the surprise of practically no one, most of the problems came back to those two old faithfuls: "Where are we going to get personnel?" and "How do you make a good manager out of the nurse or dietitian (among others) who was never trained for management in the first place?" Specific answers there were none, although the panel wrestled manfully (or womanfully, in several cases) with each question and exhorted both the questioners and the audience to buy the manuals and make use of the assistance that the association stands ready to provide. It was a sensible suggestion, but Elvera Anderson of Methodist Hospital, Los Angeles, representing the dietitian athirst for information, set the panel back on its collective heels. Asked if she had read any or all of the impressive list of handbooks, manuals, buying guides and quantity recipes the A.H.A. has been busily turning out, she shook her head sadly and explained: "I'm sure they would all be very helpful, but dietitians just don't have the time to read."

ARCHITECT'S SESSION

At the annual meeting on hospital design Sunday afternoon preceding the opening session of the convention, Clarence Mayhew, architect, presented diagrams showing the layout of nursing units in the Kaiser-Permanente Hospital now under construction in California. Mr. Mayhew explained such features as the outside or "circulating" corridor for visitors on the nursing floors and the inside corridors for service use. Answering questions from the audience, he said this layout was economical and would reduce distances traveled by nurses from nursing sta-

Casters & Wheels for all hospital uses



For Savings Specify

DARNELL CASTERS & E-Z ROLL WHEELS

SAVE EQUIPMENT
SAVE FLOORS
SAVE MONEY
and TIME

Specify Darnell for Complete Satisfaction

Free Manual

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60 Walker Street, New York 13, N.Y.
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Now...A Practical, Efficient and Economical Method of Window Replacement or Renovation

before



This photo shows the seriously-deteriorated condition of some of the wooden sash in the Hotel Hollenden, Cleveland, Ohio. Drafts and difficulty in operating the windows were sources of complaint from guests. Water leakage and excessive dirt infiltration caused considerable trouble and expense.

after



This photo shows same Hollenden window opening after old wood windows were replaced with streamlined, Rusco galvanized steel windows, complete with insulating sash. Use of Rusco insulating sash provides rain-proof, draft-free ventilation regardless of weather. Also reduces street noises, increases heating efficiency and saves fuel, and is ideal treatment for air conditioning.

Replacing or renovating windows normally involves serious disruptions in service, heavy expense and, in many cases, a temporary loss of revenue. But The F. C. Russell Company, world's largest manufacturer of metal combination windows and developer of the unique fully pre-fabricated Rusco Prime Window, has created products and methods which overcome these problems.

Rusco can now replace or renovate your worn-out or otherwise unsatisfactory windows at a substantial saving and, very likely, without taking rooms out of service for even a day!

A Typical Example: Hotel Lafayette, Buffalo, N. Y.

The Hotel Lafayette was faced with a serious situation because the old wood windows were so deteriorated that complete replacement was necessary. Photo at right shows The Lafayette as it looks with Rusco galvanized steel windows installed in place of the old windows. Manager K. A. Kelly says, "The time consumed for installation, I believe, was about two months and this was done at a time when we were running to capacity every night. During that period we did not have as much as one complaint of inconvenience to the guests. In fact, when the windows were delivered to the hotel, a floor or two floors at a time, we would place the material in the clothes press of the room and place a card on the clothes press door explaining that these were new windows to be installed for the convenience of our guests.

"Aside from the fine features of eliminating dust and dirt and doing away with the extreme draft in cold weather, our window screens were a major problem for us and with the permanent installation of screens our headache has been eliminated.

"We feel that our money was spent very wisely and we have had nothing but the finest reaction from our guests, particularly from those who have been steady patrons of the hotel for a number of years and knew only too well what conditions existed with the old windows. I can recommend these windows most highly."



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3. If present windows are not too seriously deteriorated, an installation of Rusco Combination Windows to serve as the primary windows will preserve them and make window openings fully weathertight.
4. Rusco glass inserts are interchangeable and removable from inside the building. By keeping a supply of spare inserts on hand, window washing and repair of broken glass can be accomplished speedily and without any inconvenience to guests or tenants. Spare inserts are slipped into window and removed inserts taken to central point for washing or re-glazing.

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tions and utility areas to patients' rooms.

Dan Brown, administrator of the Kaiser Medical Center, now under construction in San Francisco, said the hospital layouts were designed for the physical comfort and mental well-being of patients. He emphasized features which brought the maximum number of services to the patient's bedside and thus permitted economies in both nursing and medical personnel. The design, Mr. Brown said, was aimed at permitting the hospital to have fewer but better trained and higher paid persons in the nursing services.

In another presentation, Dr. John Newdorp, assistant medical director of the United Mine Workers Welfare and Retirement Fund, explained that the fund was building its own hospitals in the Eastern coal mining areas in response to a proved need for better facilities. Careful investigation had substantiated many complaints from miners and their families about hospital and medical services received from private practitioners and community hospitals, he said. Because correction of the situation proved impossible, the fund decided to provide its own facilities, and thus enjoy the benefits of standardized service and economy made possible by centralization of certain hospital services, such as laundry and supply.

Describing the procedure under which planning activities were carried on, Dr. Newdorf reported that members of the fund staff and architectural firms involved in the projects formed "banded teams" to decide problems of design, construction, materials, methods and equipment. When the construction program is completed, he said, standard operating and administrative technics and methods will be taught to personnel in fund hospitals and carried out in all the hospitals in the group.

Dr. David Wilson described the integration of teaching and service facilities planned at the University of Mississippi Hospital. One of the first teaching hospitals to be constructed in the television area, the University Hospital has eliminated amphitheaters or viewing stands in operating rooms and will use television for teaching surgical procedures, Dr. Wilson reported. All operating rooms are the same size, he said. The hospital also features movable partitions to provide functional flexibility in areas devoted to teaching and research projects, he said.

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P.H.S. Report Reveals Health Problems in Eight-State Area

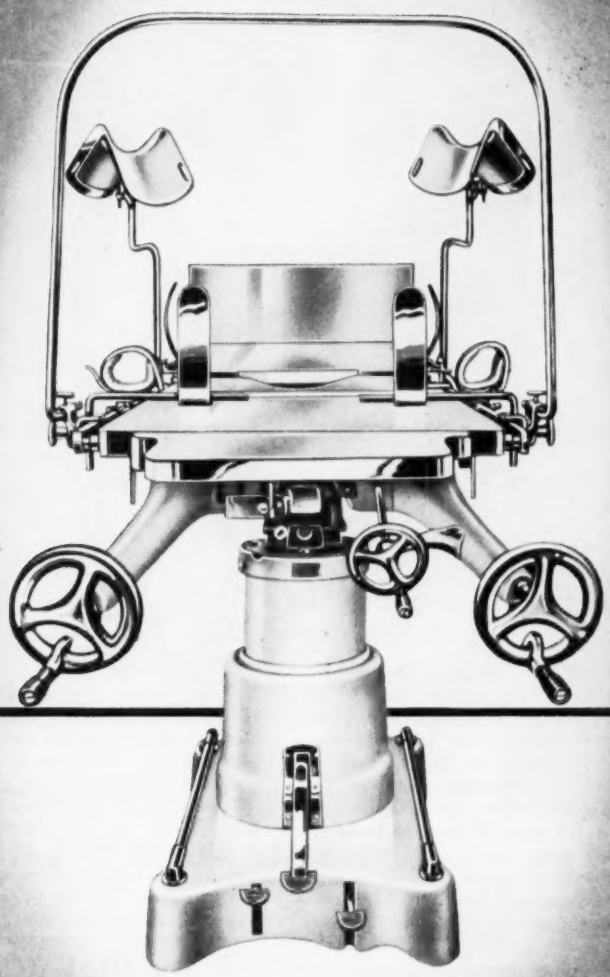
LITTLE ROCK, ARK.—A shortage of hospital beds and insufficient "health manpower" confront approximately 7,000,000 people in the Arkansas-White River-Red River Basin area, according to a report released here last month by the U.S. Public Health Service following a study of the area's health resources, which was part of a comprehensive economic survey being conducted by several federal agencies under the coordinating direction of the U.S. Department of Commerce.

The area studied has only 2.9 general hospital beds per thousand population, the report said, compared to the ratio of 3.6 beds per thousand for the country as a whole. An

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Several years ago Hill-Rom pioneered the idea of an auxiliary safety step attached to a hospital bed. This original safety step has enjoyed wide acceptance among hospital officials. This new model embodies many improvements and refinements in design which make for *increased safety* and convenience. ALL THE WEIGHT is carried on the floor, with practically no strain on the bedrail. This new safety step can be *easily attached to any standard hospital bed* —old or new, wood or metal.

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NEWS...

additional 10,000 hospital beds are needed to bring the ratio up to the level of the New England and Middle Atlantic states, it was indicated.

In addition, more than 9000 nurses —an increase of 56 per cent—would be needed to bring the area's nurse ratio up to that of the country as a whole, the report said. The Arkansas-White River-Red River Basin has 65 hospital nurses per 100,000 population, exclusive of private duty nurses, and there are 116 counties in the area which have no public health nurses. Nursing deficiencies are especially marked in Arkansas and Eastern Oklahoma, it was indicated.

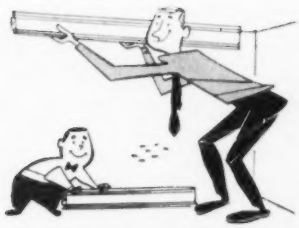
While the supply of physicians for the country as a whole was increasing by 12 per cent during the years 1940 to 1949, the number of physicians in the surveyed area dropped 7 per cent. Within the area, physician manpower varies from 120 doctors for 100,000 population in the Colorado counties studied to half that number in New Mexico. The report also noted that a disproportionately large number of physicians in the area are in older age groups.

The area studied included the entire state of Oklahoma and 237 adjoining counties in parts of Arkansas, Colorado, Kansas, Louisiana, Missouri, New Mexico and Texas, it was indicated.

Iowa Sponsors Series of Nursing Workshops

IOWA CITY, IOWA.—The first of a series of workshop conferences for nursing service personnel in Iowa hospitals was held at the State University of Iowa here last month under the sponsorship of the university's college of nursing. Directors of nursing service, supervisors, head nurses and staff nurses from Iowa hospitals attended the workshop and took part in discussions seeking methods of streamlining nursing service to make the most efficient possible use of the time and energy of the limited supply of nurses available, the college reported.

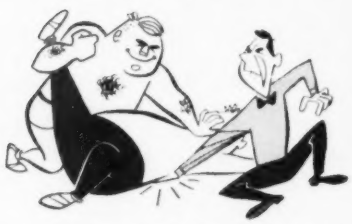
The conference was the first of a series of five to be held at the university during the school year, continuing a program which began last April under a grant from the W. K. Kellogg Foundation. The university is one of 14 institutions which have received similar Kellogg grants for nursing education studies.



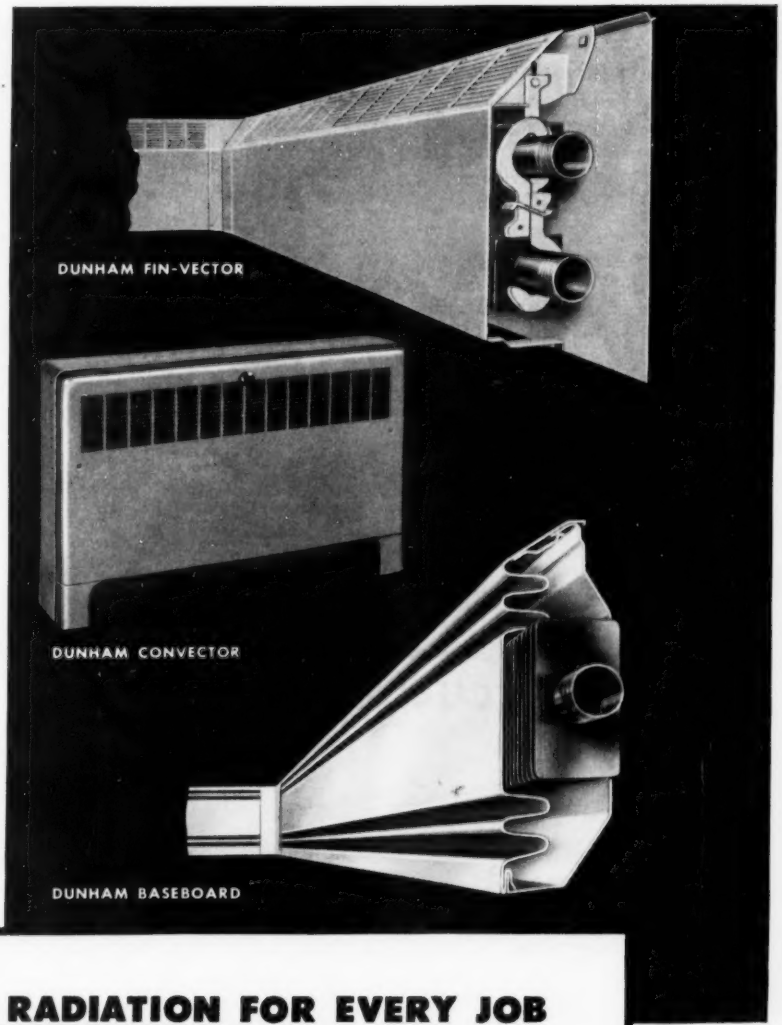
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NEWS...

A.D.A. Convention; Bulman Is President

(*Continued From Page* 122)

of animal metabolism even in carnivores. Unexpected observations led him to locate the production of sugar in the liver, and to postulate the existence in this organ of a substance giving rise to the sugar appearing in the blood. To this precursor he gave the name "glycogen" and after more than a decade of experimentation he succeeded in isolating it as a white powder, and in showing its rôle in the maintenance of the blood sugar level.

Spanning the intervening century with its other discoveries which have formed the basis of our present treatment of diabetes, Dr. Samuel Soskin, editor-in-chief, *Clinical and Experimental Metabolism*, said it is now known that insulin is not essential for the oxidation of carbohydrate and it no longer can be said that the diabetic must limit his intake of carbohydrate and its precursors because he lacks insulin. We now know that the diabetic disturbance results chiefly from an impairment of the regulation of the blood sugar level. Not only the pancreas but other glands, the anterior pituitary, adrenal cortex, and thyroid, may be involved; the liver also is a very important factor. The need of a controlled though otherwise normal diet is now reasonably based.

STUDIES ON HEART DISEASE

Man's conquest of the killer diseases, scurvy and diabetes, is now headed toward another, wider in its implications—heart disease. Dr. John W. Gofman, associate professor of medical physics, University of California, said that a study of the serum lipoproteins in the human being reveals that certain classes of these are strongly associated with human atherosclerosis and coronary heart disease. These lipoproteins may now be measured with the ultracentrifuge to yield a value designated as the atherogenic index or rating of the individual with respect to coronary heart disease. Obesity, a priori the result of excessive calorie consumption, is associated *on the average* with elevation of the atherogenic index. True, some obese persons may have low atherogenic index values, while some lean ones have high values. Yet the correcting of obesity will generally lower this value in many if not all individuals. In any case, a reduction in dietary fat intake will reduce the index, which if elevated means that atherogenesis is progressing.

Pursuing this subject further, Dr. Laurance W. Kinsell, director, Institute for Metabolic Research, Highland-Alameda County Hospital, Oakland, Calif., said that in the course of controlled metabolic studies a consistent and major fall in the level of serum cholesterol and phospholipids occurred when large amounts of vegetable fat were administered, whereas when the fat was derived from animal sources these levels were essentially the same as those which occur on an average mixed diet. The changes noted may be due to the absence of one or more factors in the vegetable fat, *e.g.* cholesterol, or to the presence of some other factor—vegetable sterols or phospholipids.

Tuberculosis, once a scourge, was discussed from the nutritional stand-

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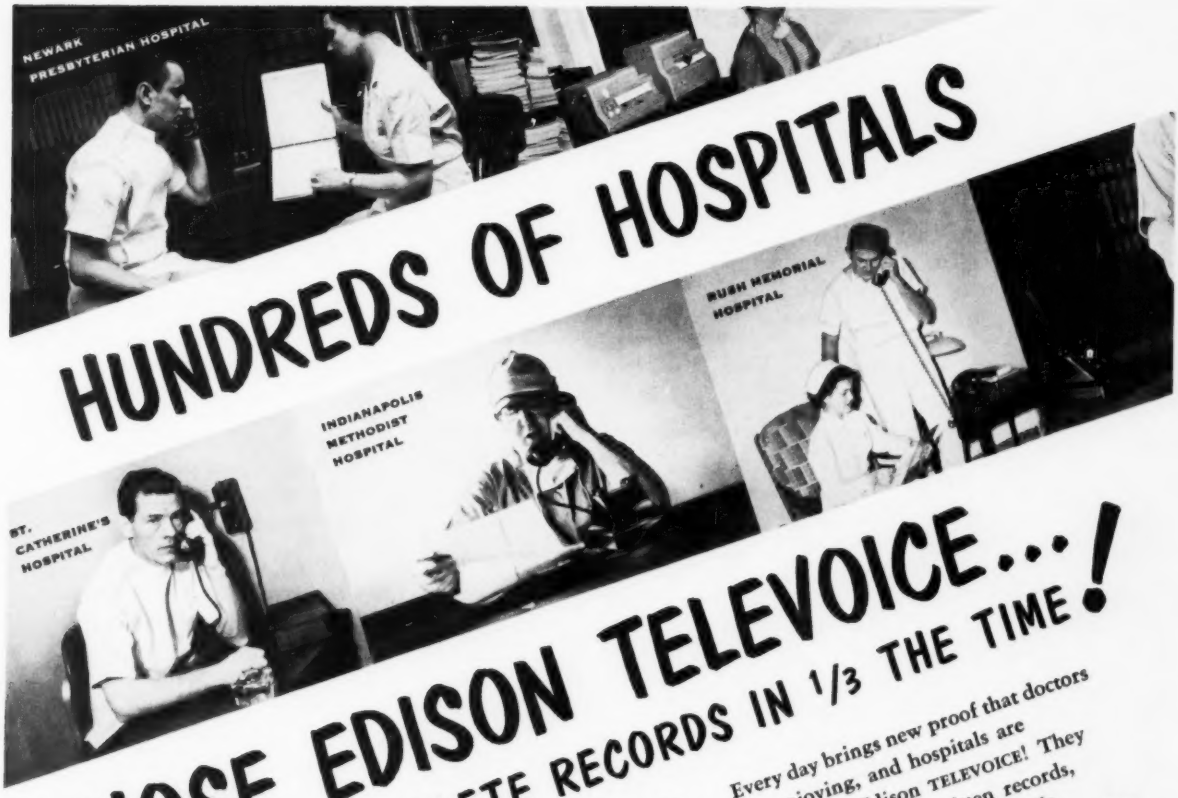
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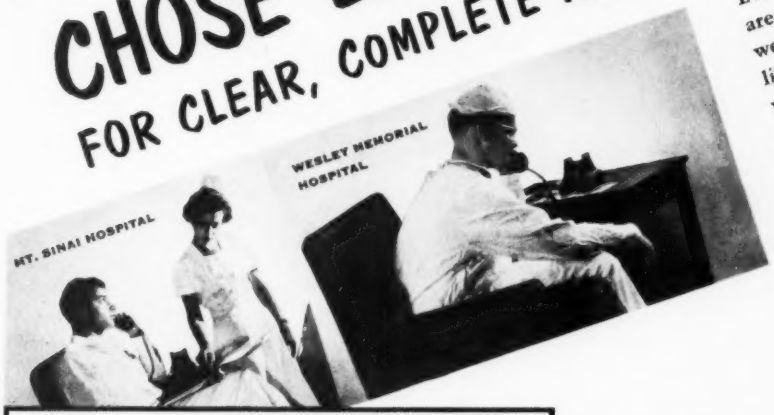
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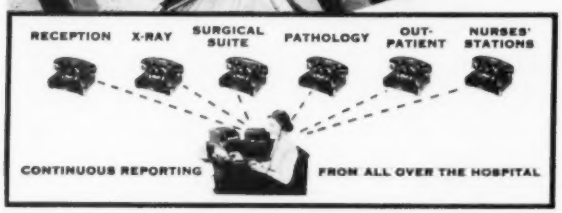


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point by Horace R. Getz, medical director, Charles Cook Hastings Home, Altadena, Calif. "A typical case of tuberculosis entering a sanatorium is still an advanced case." Such a patient has specific nutrient needs: generous amounts of proteins, vitamins A and C. The low levels of vitamin A found in tuberculous patients coincides with a relatively high level of carotene, suggesting that a conversion of carotene to vitamin A is poor or completely blocked. A low serum albumin is also noted in cases of long standing and advanced stages of the disease. Almost all such cases have tuberculous ulcers of the intestinal tract at some time; hence there is faulty absorption. All irritating foods should be omitted from the menu, a "prime offender" being the onion. The intensified need for vitamins A and C becomes both a medical and a dietetic problem, with the dietitian doing all in her power to supply these in the diet. When the disease is actively progressing "it is almost impossible to saturate a tuberculous person with vitamin C."

The actual serving of food need not be especially difficult. A "clean" cart delivers the food to the patients' quarters and is removed immediately; a "dirty" cart is then used to pick up the contaminated trays. Tuberculosis is spread only by tiny infecting nuclei that are blown out of the patient and remain suspended in the air like tobacco smoke, to be breathed in by a new host through the bronchial tree into the air cells. Tubercle bacilli on contaminated trays can be a menace only if they are suspended in tiny nuclei of a size capable of passing through the entire bronchial tree.

PROBLEMS OF MENTAL PATIENTS

Nutritional problems of psychiatric patients were not overlooked. Dr. Douglas G. Campbell, professor of psychiatry, University of California, said that some derive from conscious or unconscious attitudes toward the consumption of certain nutrients, or the effects of emotional conflicts upon intestinal absorption and cellular metabolism. Other nutritional disturbances may be only indirectly psychogenic, arising from external influences —tradition and custom, economic conditions, misleading advertising or medical treatment. Or an existing malnutrition may stem from somatic ill health of recent or remote origin. Whatever its origin, malnutrition does affect the nervous system in varying degrees. Thus we see the well known neuropathies and the less easily recognized disturbances of the higher neuropsychic functions of mood, intellect or social behavior. "Since the nervous system is completely dependent on nutrients mediated to it by other organs of the body, and since the nervous system regulates metabolic processes in the body which feeds it through psychophysiological mechanisms, a self-regulating or 'feed-back' mechanism exists which must be taken into account in both diagnosis and therapy. Somatogenic and psychogenic sources of malnutrition become interrelated; vicious circles that produce, maintain and aggravate disease occur."

Now that the vitamins are reaching the end of the alphabet, a suitable introduction to the recent advances in applied nutritional science might well



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NEWS...

lead off with vitamin U therapy in the dietary management of peptic ulcer as reported by Garnett Cheney, clinical professor of medicine, Stanford University. Peptic ulceration of the esophagus, stomach and small intestine is caused by the action of an acid solution of pepsin upon the mucosa when there is lowered resistance to such digestive agents. Two factors are primarily concerned: the peptic digestion attacking the membrane, and the latter's degree of resistance. This resistance is ordinarily high if there is adequate intake of the food factor termed vitamin U, and low if there is a deficiency or interference with its utilization. Not yet isolated, the vitamin, present in green vegetables and their juices, especially cabbage, is readily destroyed by heat. One hundred patients treated with fresh cabbage juice have responded very satisfactorily. Another hundred, treated with vitamin U concentrate prepared from fresh cabbage juice by a cold process, have responded equally satisfactorily. Pain usually abated on the fourth or fifth day.

Perhaps less emphasis was placed on food technology this year than previously. According to Dr. Emil M. Mrak, professor of the subject in California's college of agriculture, truly great advances have been made in recent years. "The consumer is certainly losing interest in foods that take a tremendous amount of time for preparation." Storage life, too, is being given greater consideration. If foods change color, flavor or texture, acceptability decreases sharply. Interesting developments have been: the lower temperature concentration of citrus juices which favors both acceptability and nutritional value; the introduction of sliced cheese which increases sales and actually decreases loss from molding and drying out; dried fruits with 30 per cent moisture and hence a higher acceptability rating for eating "out of hand" as well as cooking. The potato granule, not yet widely used, to which the consumer need add only a little hot water, stir, and have mashed potatoes, bespeaks a further revolution in certain aspects of cookery. Other new items are tomato juice concentrate, the Martin process of canned items, new type of processed corn, low methoxy desserts, newer methods of cooking storage jellies, continuous process for rendering lard, liquid sugar and others.

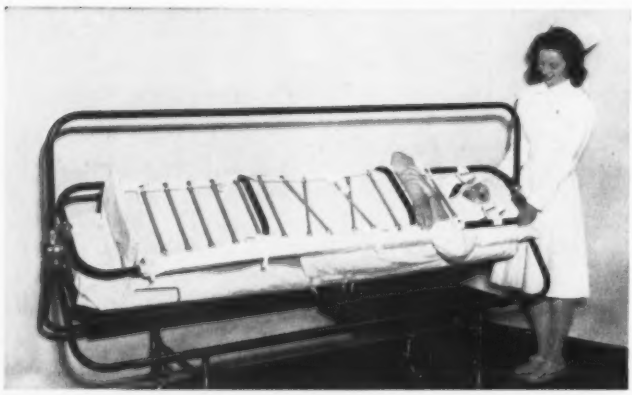
Dr. Helen L. Hanson, U.S.D.A., Albany, Calif., foresees an increasing demand for convenient, completely cooked foods that require only thawing and heating. The problems of maintaining stability during freezing and frozen storage are being overcome; so is the development of rancid flavors in items such as precooked frozen turkey.

From another angle Dr. Agnes Fay Morgan, University of California, said that "a decrease in the biological value of food proteins occurs whenever the foods have been subjected, even briefly, to cooking or processing temperatures in excess of the ordinary boiling point or have been maintained at this or lower temperatures for longer periods of time." Loss varies not only with temperature and time but with the nature of the protein and compositions of other constituents of the food. "Browning reaction" noted in dried and evaporated milk, dried eggs and

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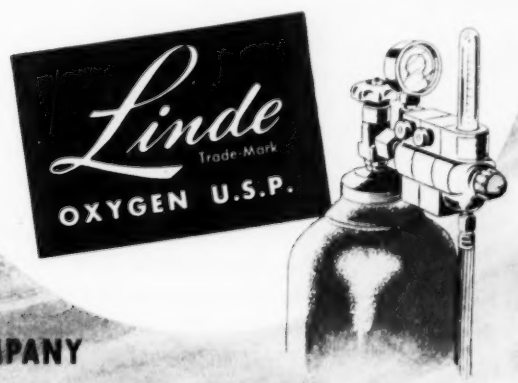
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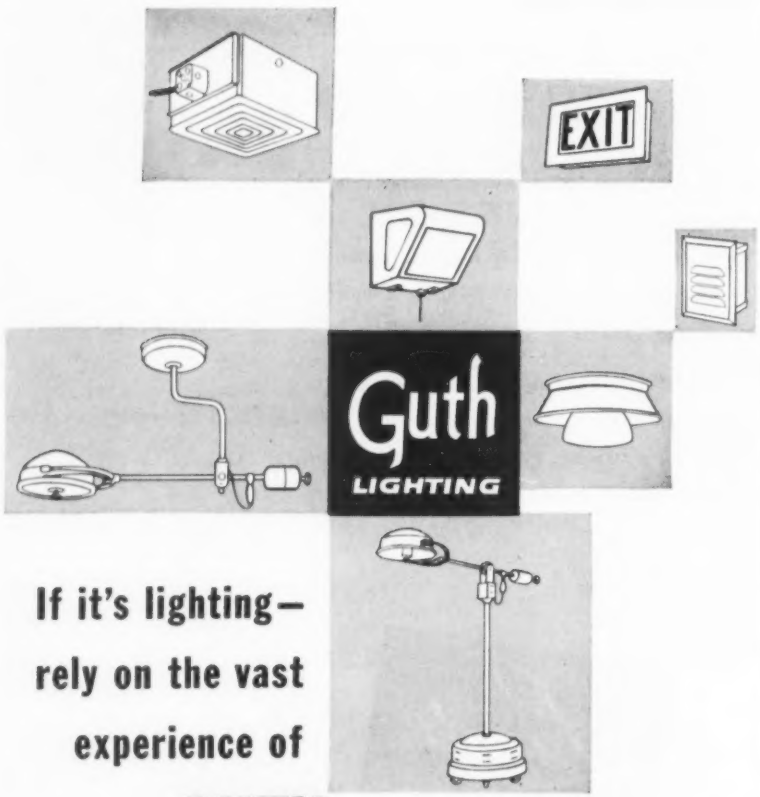
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fruit refers in part to the combination of certain amino acids with reducing sugars. But more serious breakdown of the protein molecule occurs on exposure to higher or prolonged temperatures and these changes are irreversible. In storage, the browning reaction is accelerated by increased temperature. The choice of pressure or steam cooking, frying, broiling or oven baking and the conditions of storage should be made with these considerations in mind.

A dietitian food operations consultant to one of America's great industries, Dorothy Milavetz of the E. I. du Pont de Nemours Company, said that economy in her department is under the same management policies as the production lines in the plant. Not the "penny-wise, pound-foolish economy of immediate savings" but a long-range one through which sufficient investment, capably administered, yields greater satisfaction. She employs well designed layouts with the most functional equipment, using to the utmost the principles of motion economy; individuals well trained and capable of profiting by good training; well defined job responsibilities and work guides; competent supervisors, and specialized assitance, when needed, from other food specialists and industrial engineers. Of her system she believes that the job description and guide "is the very core and matter."

At the final session the association's highest honor, the Marjorie Hulsizer Copher Award for 1953, was presented to Mable MacLachlan in acknowledgement of her "meritorious leadership . . . her inspiration and guidance to dietetic interns . . . her integrity and loyalty to the profession of dietetics." The Lydia J. Roberts Essay Award for 1953 went to Dorothy L. Jefferson, the Mary Swartz Rose Fellowship for 1953 to Margaret L. Ross. Philadelphia is the convention city for 1954.



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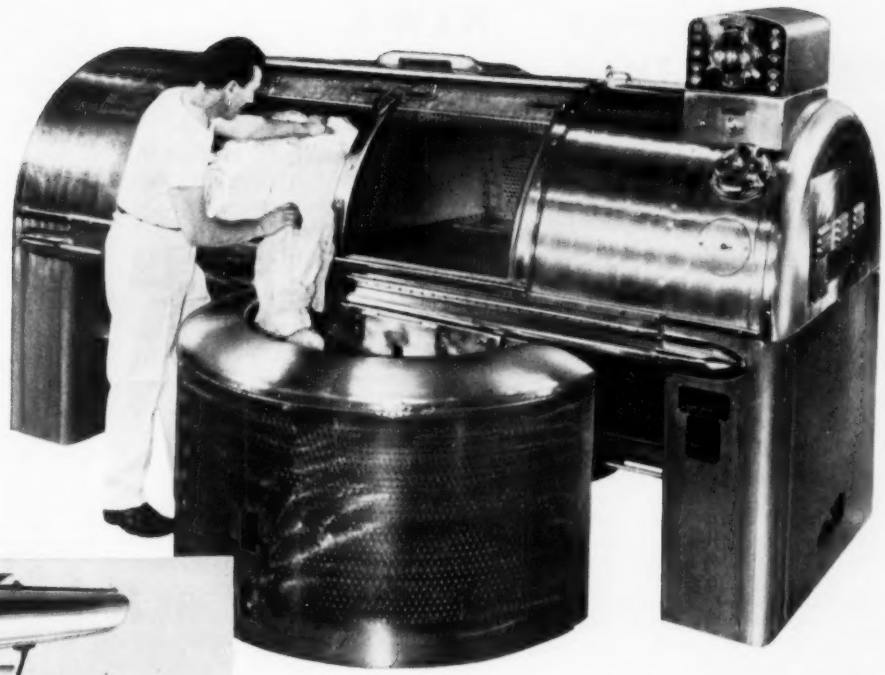
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Inter-Agency Institute Opens on October 26

WASHINGTON, D.C. — Leading authorities will discuss important and varied methods employed in the field of hospital administration during the seventh Inter-Agency Institute for Federal Hospital Administrators to be held here at Walter Reed Army Medical Center, October 26 to November 13, announced Col. James T. McGibony, MC USA, commanding officer, U.S. Army Hospital, Fort Belvoir, Va., and chairman of the inter-agency committee on the training of hospital administrative personnel.

Lectures will cover personnel problems, hospital design and construction, maintenance and housekeeping, budget operations, supply operations, hospital records, management improvement, professional relations, public relations, nursing service, food service, catastrophe planning, and executive leadership. Small discussion groups will also be conducted to permit question and answer periods and analysis of individual hospital problems, the program announcement said.

Col. Kermit H. Gates, MC USA, deputy post commander of Walter Reed Army Medical Center, has been named this session's institute director. Other committee members include Col. McGibony, Pierre Palmer, Dr. Max Van Sandt and James Cunningham.





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NEWS...

Armed Forces Have Too Many Physicians, A.M.A. *Journal* Charges

CHICAGO.—Local communities are handicapped and individual physicians may be seriously inconvenienced by the fact that the number of physicians who have volunteered for active duty in the armed forces now exceeds medical officer requirements, the American Medical Association declared here last month. "Despite this, the Selective Service System refused to cancel its latest physician draft call which forced 524 physicians to accept reserve commissions and apply for immediate active duty," the association stated.

In July this year, the Defense Department requested 524 physicians from the director of the Selective Service System, according to an article in the *Journal of the American Medical Association.* The physicians were called up through state and local selective service agencies, it was explained, and, shortly thereafter, "a flood of applications for reserve commissions and active duty orders was received from physicians in priorities 1 and 2 who had previously been temporarily deferred for reasons of essentiality and to complete internship and residency training."

Volunteers now exceed 1200, a number "far in excess" of present medical requirements of all branches of the armed forces, it was explained.

"It appears certain not only that the current draft call was unnecessary, but that there will be no more such calls for many months to come," the *Journal* said.

"Acting in good faith and on the basis of assertions by officials in Washington that medical personnel was sorely needed," the *Journal* continued, "many of these men have closed their offices or have discontinued their plans for additional residency or postgraduate training." In many instances this discontinuance of training was forced on them because of the prohibition that prevented hospitals from accepting priority 1 and 2 men to fill available residency vacancies.

"Having terminated their civilian commitments on the assumption that they were needed immediately by the armed forces, these physicians are now faced with the prospect of an indefinite status for the next year or more."

The *Journal* article said the long-range effects of piling up an excessive

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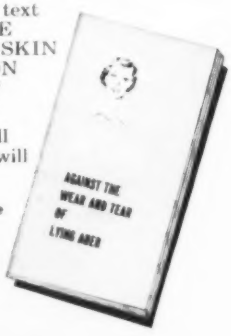
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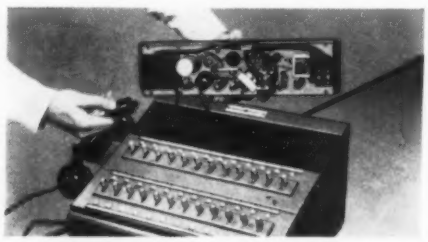
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NEWS...

number of medical officers would result in wastage of medical manpower, reduction in the number of physicians available to care for the civilian population, and inefficient utilization of physicians in service, "with a resulting lowering of morale and general dissatisfaction with military service."

New York Council Reviews Formula for Estimating Bed Needs

NEW YORK. — Formulas for determining needs for hospital beds are not entirely satisfactory, according to a report released here last month by the Hospital Council of Greater New York.

Mathematical formulas play an important but not exclusive rôle in estimating hospital bed requirements, the report said. "It is necessary to employ a formula in order to afford equal and objective treatment to several areas," it continued. "At the same time, it is appreciated that a formula does not usually embrace all the economic, social and health factors that influence the need for hospital care. Results yielded by a formula must be intelligently judged and constantly evaluated in terms of actual experience in the utilization of hospitals."

In an article published in the council *Bulletin*, the council reviewed formulas based on population, hospital utilization and mortality. The formula used in estimating bed requirements under the master plan for New York City, developed by the council, is based on the number of general care patient days per death and an optimum average rate of occupancy of 80 per cent for general hospitals, the report noted.

"It may be that today a hospital can cope with a higher average rate of occupancy for a year than in the past," the *Bulletin* concluded. "However, the rate of occupancy used in planning bed requirements for the community as a whole depends on distribution of its hospitals by size of bed capacity, on the flexibility of hospital accommodations, on the range of fluctuation of hospital admissions over the seasons, and on the practices of hospitals and physicians in scheduling admission of nonemergent patients. Whether the 80 per cent figure should be retained as optimum or a higher one substituted is a question calling for study."

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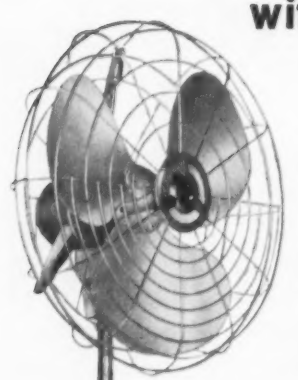
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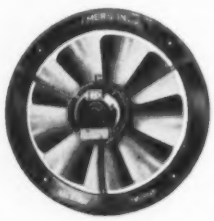
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NEWS...

Announce Plans for Improving Facilities of Three Nebraska Institutions

OMAHA, NEB.—Negotiations among three of Nebraska's major medical institutions here have resulted in agreements contemplating expenditures of between $4,500,000 and $5,500,000 for the improvement of medical and affiliated facilities of Lutheran Hospital and University of Nebraska medical campus and the erection of a new Bishop Clarkson Memorial Hospital, the university hospital announced here last month.

Contracts signed by boards of the institutions concerned provide for the sale of the existing Clarkson Hospital and nurses' home to Lutheran Hospital; a new Bishop Clarkson Hospital will be erected near the University of Nebraska medical campus at 42d Street and Dewey Avenue—costing between $3,000,000 and $4,000,000.

According to the contract, Lutheran Hospital will take possession of Clarkson properties and the new hospital will be erected within the next two years.

The Clarkson nurses' home is to be converted into a modern old people's home for Lutherans, it was announced, providing care for 110 residents instead of the 37 the Lutheran Hospital can now accommodate.

In announcing the sale of present facilities, Rt. Rev. Howard R. Brinker, president of the board of trustees of Bishop Clarkson Memorial Hospital, said that the Episcopal group has purchased land to erect a new hospital and that the Leo Daly Company, architects, is drawing up plans for the new building which will have a capacity of approximately 250 beds.

Clarkson will continue all of its present services, as well as cooperating with the university in training nurses, laboratory and x-ray technicians, dietitians, physical therapists, occupational therapists, medical students, interns, residents and other trainees.

According to John K. Selleck, acting university chancellor, the agreement with Clarkson will in no way change the university's plans for the development of a medical center. Said Mr. Selleck, "The agreement with Clarkson merely clears the way for the new Clarkson Hospital to become, in effect, a part of the medical center and in a position to participate to the fullest possible extent in providing the clin-

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NEWS...

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Blue Cross Exhibit at County Fair Attracts 30,000

BUFFALO, N.Y.—In a combined effort to improve public understanding of the cost of hospital care, 37 voluntary hospitals in the western New York area and the local Blue Cross Plan, Hospital Service Corporation of Western New York, presented an exhibit at the Erie County Fair here last month.



Blue Cross display at Erie County Fair featured a tableau of an operating room equipped for surgery.

The exhibit featured a large display panel locating hospitals on a map of western New York State, photomurals illustrating hospital services and separate display panels giving the facts of hospital service for the area.

In addition, the display featured a life-size tableau of an operating room equipped for major surgery. Equipment for this display was furnished by manufacturers, and a local department store provided the manikins for the tableau. Attendants from the Blue Cross Plan were on duty at all times to answer questions and tell the hospital story.

More than 30,000 people visited the display during the course of the week, the Hospital Service Corporation reported. "The opportunity to talk to large numbers of people outside the hospital atmosphere, and find out what they really thought about their hospitals and what hospital care does and should cost proved to be a most valuable experience," a Blue Cross report stated.

TABLEAU WAS GREAT ATTRACTION

At the same time, the booth attendants had many opportunities to dispel superstitions, fears and misconceptions concerning the modern hospital and medical care. "Use of the operating room tableau proved worth while since it attracted and held more people for longer periods of time than could have been expected from the use of display panels alone. This was verified by surveys made of visitors to the exhibit buildings and is considered important, since it has a direct relation to the ability of visitors to remember what they have seen and heard."

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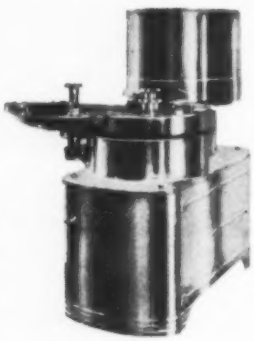
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Health Resources Committee Lists Ways of Meeting Personnel Shortage

WASHINGTON, D.C.—In a statement released by the Health Resources Advisory Committee here last month, hospitals, doctors and nurse executives were urged "to give immediate and thoughtful attention to devising means of providing adequate care to patients without expanding nursing staffs."

To accomplish this result, the committee recommended objective analysis of hospital functions without regard for tradition. "Dispassionate scrutiny of each task within the hospital will show whether it is really necessary for the welfare of the patient and whether it is being performed in the most economical manner from the standpoint of time and choice of personnel," the committee stated. "In such an analysis it will become clear that in many instances new medical technology has made existing routines unnecessary. Many current hospital routines are based on assumptions which are no longer valid. In this era of short patient stays, many hospitals will find that the patient will need to be shown the medical advantages of doing for himself many things that customarily have been done for him by nursing personnel."

Predicting that the shortage of skilled hospital personnel will be with us for a long time, the committee pointed out that the shortage is the product of trends in medical care which will not be reversed. "Our only course of action is to recognize these trends and set ourselves to the task of finding new solutions," the committee declared.

The committee said its studies have indicated that, while nurse recruitment and recruitment of auxiliary personnel for hospital services has increased in recent years, the rapidly increasing demands for service have nevertheless outstripped the supply.

Urging hospitals to cast off the "shackles of tradition" in studying personnel needs, the committee recommended the following steps for all hospitals:

1. The team approach as a technic of management.

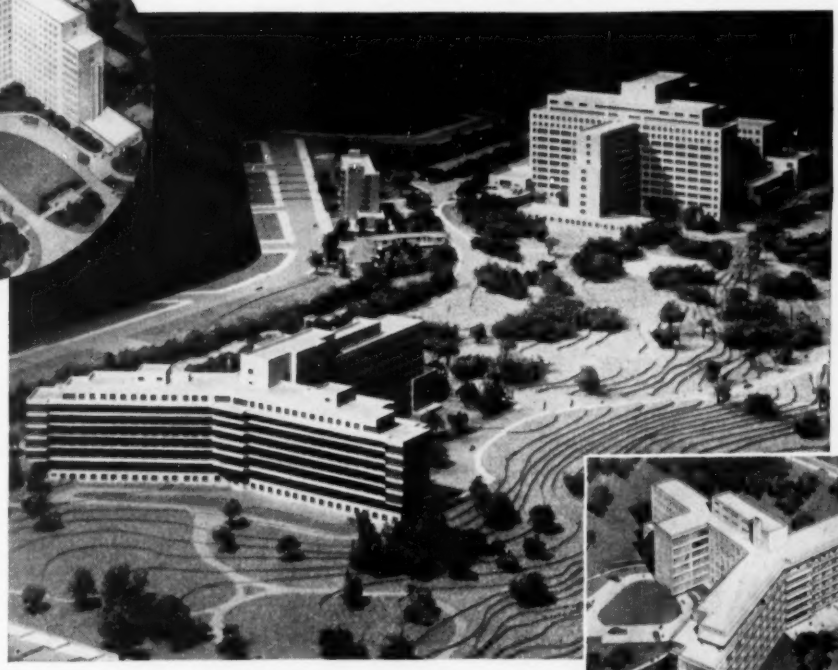
2. Use of modern management technics generally to increase productivity of workers, "though they require an initial increased investment of time

(*Continued on Page 186*)



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GENERAL HOSPITAL, Staff Quarters and Superintendents' Houses, *upper half of illustration*

TUBERCULOSIS HOSPITAL, (Service Buildings not shown) *lower half of illustration*

POMERANCE & BREINES, *architects* • GUY B. PANERO, *mechanical engineer* • GERACE & CASTAGNA, *general contractor* • JOSEPH F. EGAN, *plumbing contractor, Tuberculosis Hospital* • ASTROVE PLUMBING & HEATING CORP., *plumbing contractor, General Hospital* • CRANE CO., *plumbing wholesaler*

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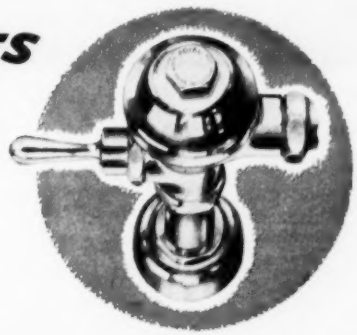
• On a rugged 60-acre site, previously unwanted for other purposes, forward-looking medical and architectural specialists are seeing their dream become reality. They have done masterful planning, not only for the present but to create a giant center for teaching and practice that will be adaptable to future years of health service and medical progress. Such planning resulted in many innovations. In the Tuberculosis Hospital all showers are equipped for wheel chairs and walls have handrails to aid walking. Each floor has its own dining room and many unusual features. In the General Hospital, the kitchens are located on alternate floors, with serving pantries on nonkitchen floors. When planning so vast a project it is logical that all equipment shall measure up to exacting standards. To have had its Flush Valves chosen for installation throughout these unusual buildings is a source of pride to SLOAN and another preference that explains why . . .

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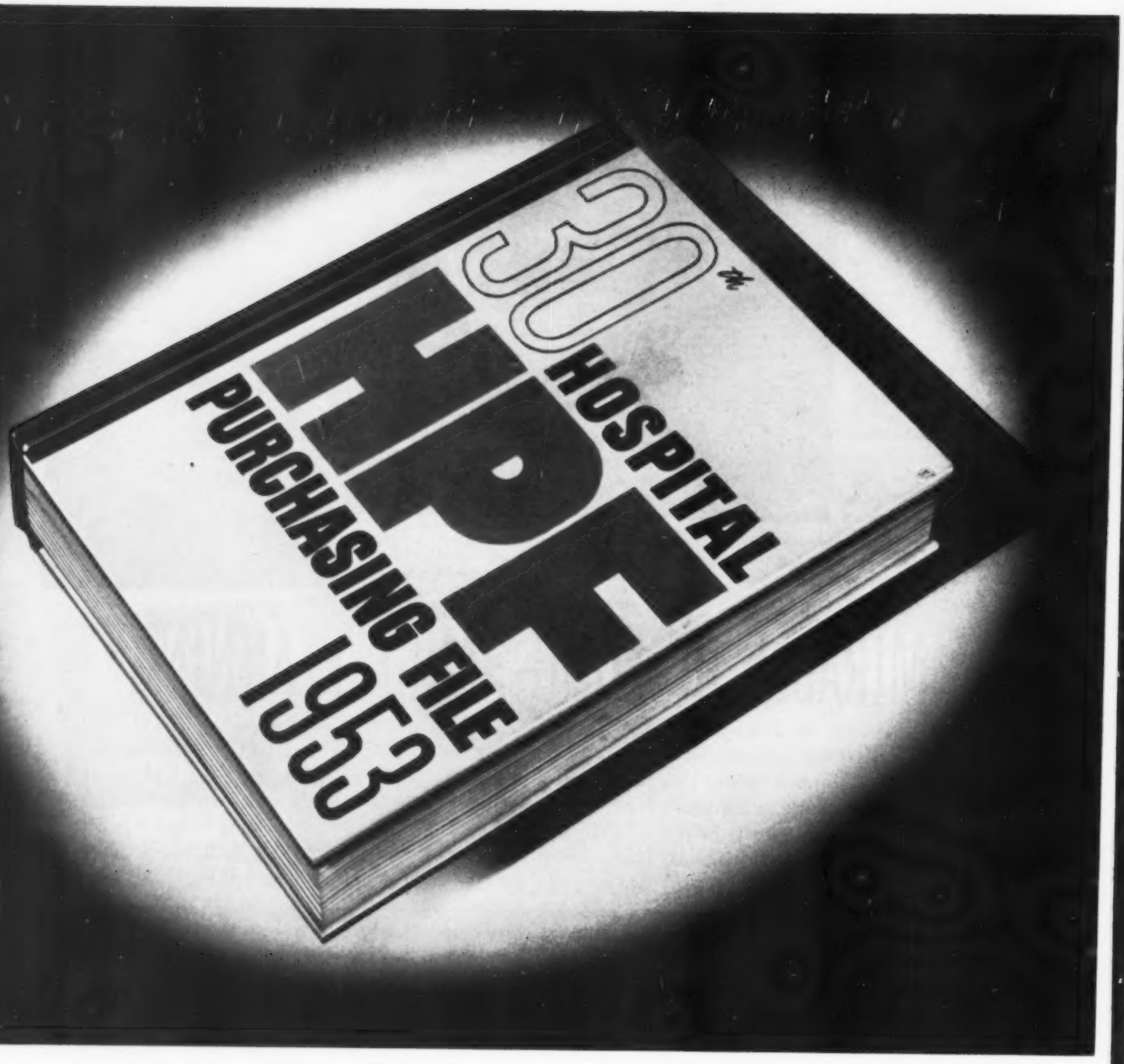




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NEWS...

(*Continued From Page* 182)

by the key people in the hospital."

3. Recognition that job satisfaction is of primary importance to all workers, and, "salary scales should be commensurate with local markets."

4. Attention to the development of leadership skills.

5. Leadership by physicians in the effective use of paramedical personnel.

6. Leadership by chiefs of medical departments in educating physicians to accept administrative routines and cooperate in the development of advantageous operating policies.

7. Broadening concept of nursing functions, aimed at "relinquishing to other departments the supervision of institutional services."

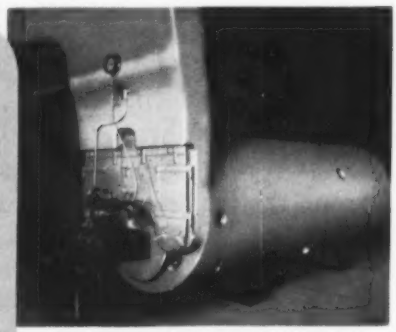
8. Continuous job analysis "to make sure that most professional and nonprofessional personnel are being used to maximum advantage."

9. Staff cooperation to increase the effectiveness of personnel by reviewing daily orders and standing orders, facilitating prompt discharges, scheduling rounds and other procedures economically and cooperating in the standardization of supplies and equipment.

10. Improved methods of recruitment, training, and in-service training for all classes of personnel.

11. Appraisal of newer developments in architectural planning for hospitals. "Each hospital which follows through on these steps and enlists in the effort to solve the problem will have gained much," the committee concluded. "Numerous hospitals already are making progress; not even one can afford not to do so. The key to the solution lies within the individual hospital."

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A.C.H.A. Evaluates Clinics for Hospital Administrators

CHICAGO.—Administrative clinics held last spring at six Chicago area hospitals under the sponsorship of the American College of Hospital Administrators were described as "very satisfactory" by the participating administrators, according to a report released by the college here last month.

The clinics brought groups of four, five or six administrators together for three-day discussions at the six participating hospitals, it was explained.

Administrators attending the clinics were unanimous in reflecting the advantages gained through this type of program, the college report said. "They characterized their experiences as being very satisfactory and all of them were in accord with the three-day program."

Significant values of the clinic named by the group were the exchange of ideas among administrators from different regions, contact with fellow administrators having comparable problems, and the practical view of daily operations in another hospital that the clinic afforded, the report said.

"There was practically unanimous decision of the group as to the extensive contribution of the group conference method," the college reported. All but one [participants] had sufficient opportunity to participate and all subjects applied to one's own problems. More than half the participants gave considerable weight to the assignment activity method used in the clinic.

Several participants suggested that future clinics should include adminis-

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NEWS...

trators from the same type of hospitals, the report concluded. Other comments for the improvement of the group conference method suggested rotation of group leaders, continuing discussion on the same problems, and greater utilization of the material brought to the clinic by the visiting administrators.

The summary of results of the administrative clinic was part of a longer project report on the college's educational fund program. Other sections of the report covered college publications and institutes, conferences on human relations and administration, and workshop conferences aimed at training hospital adminstrators as preceptors of administrative residents.

"Hospitals are exceedingly better off from the standpoint of competent administrative personnel than they were five years ago, when this program was initiated," Dean Conley, executive director, said in a letter accompanying the report, which was released to contributors to the college's educational fund.

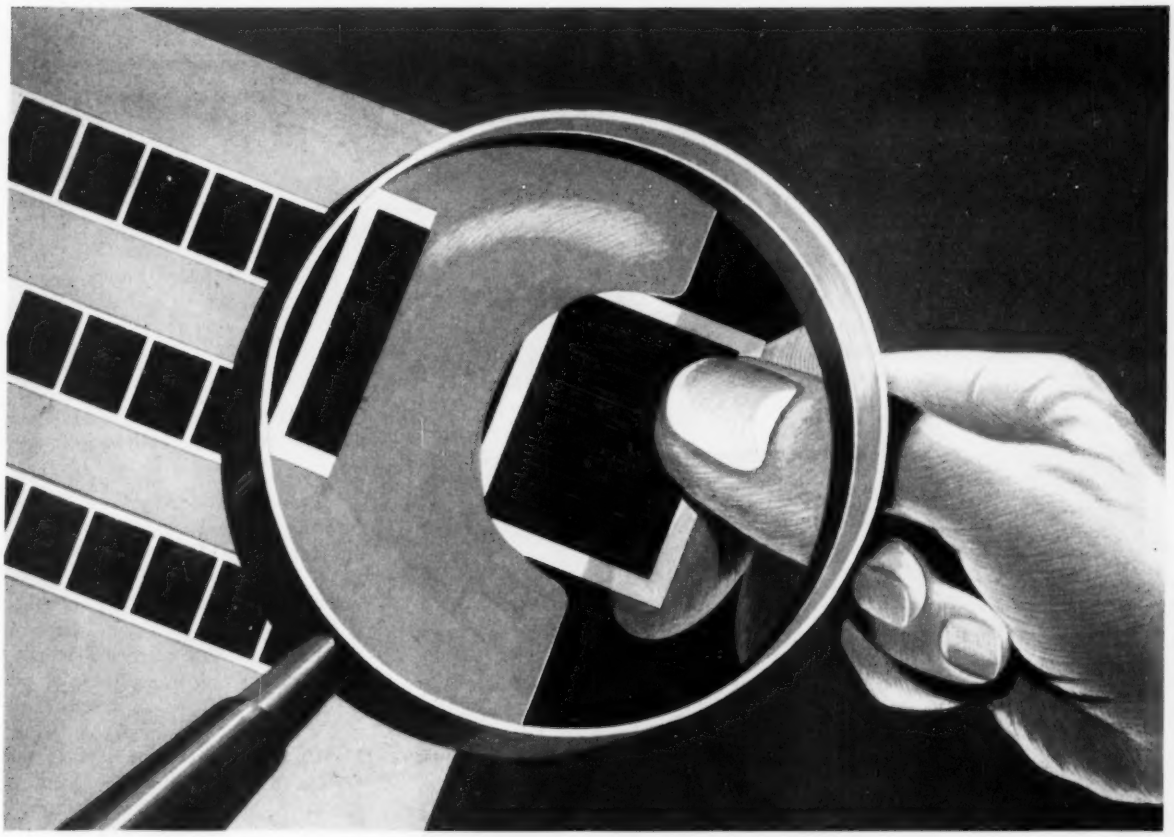
Columbia-Presbyterian Medical Center Celebrates Twenty-Fifth Anniversary

NEW YORK.—Columbia-Presbyterian Medical Center, comprising the largest voluntary hospital in the nation and one of its large medical schools, will be 25 years old this month. The occasion will be marked with a two-day celebration featuring numerous scientific discussions and demonstrations, as well as an extensive social program, the hospital announced last month.

The agreement binding the Presbyterian Hospital and Columbia University dates back to 1911 when it was agreed by the two institutions that such an alliance would "secure the best obtainable treatment of the sick and injured and provide for medical education and research of the highest type."

The medical center requires the services of more than 7000 men and women for its operation, the announcement said. Last year 35,151 patients were received, 3696 babies were delivered, and 4570 surgical procedures performed.

The two-day program marking the anniversary October 12 and 13 will feature the presentation of clinical



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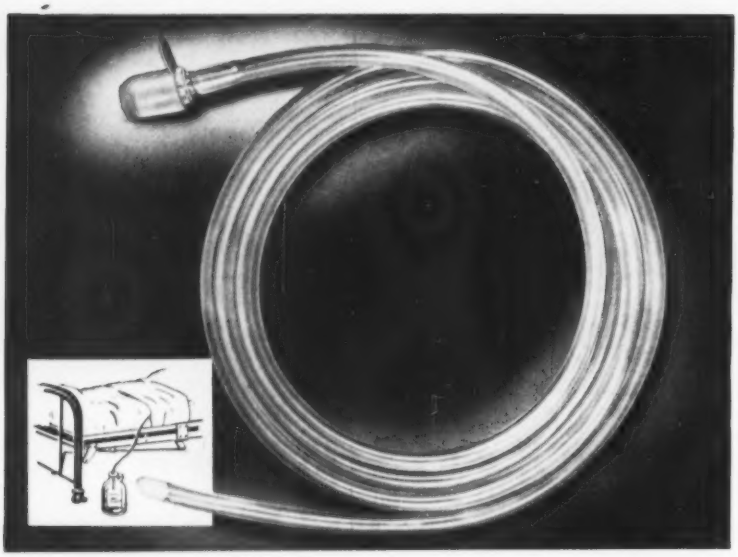
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papers and discussions, alumni and staff meetings, and social events. The program will also include an academic convocation at which honorary degrees will be awarded to Dr. Leonard A. Scheele, surgeon-general, U.S. Public Health Service, and William E. S. Griswold Sr., an active member of the board of trustees of the Presbyterian Hospital since 1922. Dr. Grayson Kirk, president of Columbia University, and Charles P. Cooper, president of the Presbyterian Hospital, are co-chairmen of the trustees committee for the anniversary celebration. Dr. Willard C. Rappleye, vice president of Columbia University in charge of medical affairs and dean of the College of Physicians and Surgeons, and John S. Parke, executive vice president of the Presbyterian Hospital, are co-chairmen of the planning committee. Dr. James E. McCormack, associate dean of the College of Physicians and Surgeons, is executive director of this committee.



Columbia-Presbyterian Medical Center as it looks on its 25th anniversary.



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There Is No Satisfactory Substitute for Quality

More Nursing Educators Needed, Study Group Says

NEW YORK. — Development of improved programs for training additional nurses depends on increasing the number of nurses trained as educators as well as nurses, a group of nurse executives and educators reported following a conference on nursing education at Teachers College, Columbia University, last month. The group of 29 represented 12 states, nine college and university schools of nursing and several government services, a report of the conference stated.

"Nurse educators must understand educational sciences and principles and have skill in developing educational programs and courses of study for the training of nurses," the report said. Change is needed in the prevalent concept of education for nurses from one of simply training students to be expert practitioners, it indicated. "Learning experiences for students of nursing should be the result of purposeful planning," the report said. "These educational experiences should be designed so that they contribute to the student's development — professional, personal and social."

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NEWS...

Alleged "Loan Shark" Activities Investigated at Elgin State Hospital

CHICAGO.—Dr. D. Louis Steinberg resigned as superintendent of Elgin State Hospital here last month, following an investigation of an alleged "loan shark racket" conducted by three hospital employes, who were suspended. The investigation was conducted by the state welfare department under the direction of Dr. Otto L. Bettag, state welfare director.

Welfare department officials charged Dr. Steinberg "failed to cooperate" in the investigation of the racket, which revealed a hospital personnel officer and two assistants had advanced money to low salaried employes at excessive interest rates.

Dr. Bettag also reported another investigation under way at the hospital, involving an alleged bookmaking operation. Earlier in the month, a handbook operation at the Chicago State Hospital was revealed when a nurse at the hospital committed suicide, reportedly because of heavy losses on horse racing bets placed through a hospital patient who was acting as a bookmaker. According to the welfare department, four hospital employes were also involved in the handbook operation.

At a meeting of the Elgin State Hospital staff several days after results of the investigation there were disclosed, Dr. Steinberg denied there was any connection between his resignation and the disclosure. Instead, Dr. Steinberg said, he had been planning to resign for several months because, he charged, Dr. Bettag did not understand the problems of mental hospitals and the welfare of patients. "I could not find it within myself to become a 'yes man' and submit to policies I could not in conscience become a part of," Dr. Steinberg said.

New Jersey Blue Cross Announces Rate Rise

NEWARK, N.J.—Two new contracts increasing Blue Cross rates in New Jersey were announced here by the Hospital Service Plan of New Jersey last month.

Replacing the present single plan, the two new types are the "comprehensive" and a "daily deductible." The comprehensive contract will cost subscribers an average of 57 per cent more than the present single plan. It will provide for inclusive services in contracting hospitals, without any payment chargeable by such hospital to the Plan patient for all hospital services generally required for the care of the patient.

The daily deductible contract will cost subscribers an average of 23 per cent more. It is also on the inclusive basis of service benefits in contracting hospitals, but the patient will be charged $5 a day, with Blue Cross paying the balance.

H. Theodore Sorg, president of the Plan, said the increased rates are based on rising hospital costs—which have risen to 60 per cent since 1948—and will go into effect for current contract holders at the expiration of the current contract year. For new subscribers they will go into effect November 1.

In explanation he said: "More subscribers have been entering hospitals, with proportion to Plan enrollment, than ever before.



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A-505—additional holders ..... each $6.00

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You can find out without cost or obligation what can or cannot be accomplished in a fund-raising campaign for your hospital by writing to Department F-10, Lawson Associates, Inc., Rockville Centre, New York. We will arrange for a free consultation at your convenience, or as a preliminary step, we will send you a copy of our new Brochure, WHEN YOUR HOSPITAL NEEDS FUNDS.

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NEWS...

"The Plan last year paid out or incurred $1,500,000 more than it earned. For the first six months of 1953 the Plan has paid out or incurred over $1,300,000 more than it earned.

"Continuing deficits would exhaust reserves. It is therefore obvious that the Plan must receive more income from subscribers to continue to make available, on a financially sound basis, the inclusive benefits which the subscribing public wants."

COMING EVENTS

AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, and AMERICAN ASSOCIATION OF HOSPITAL CONSULTANTS, Joint Session, Hotel Statler, Boston, Dec. 30.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Palace Hotel, San Francisco, Oct. 5-9.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, 19th Annual Meeting, San Francisco, Aug. 29-31; Institute for Hospital Administrators, Chicago, Sept. 14-24; Southwestern Institute for Hospital Administrators, Houston, Tex., Nov. 16-20; Human Relations Conference, Montreal, Quebec, Nov. 23, 24; Human Relations Conference, Kansas City Mo., Dec. 7, 8.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Los Angeles, Oct. 18-21.

AMERICAN SURGICAL TRADE ASSOCIATION, Hotel Statler, New York City, Dec. 13-15.

ARIZONA HOSPITAL ASSOCIATION, Annual Meeting, Hotel Adams, Phoenix, Nov. 19-21.

CALIFORNIA HOSPITAL ASSOCIATION, Hotel Mar Monte, Santa Barbara, Oct. 29, 30.

COLORADO HOSPITAL ASSOCIATION, Antlers Hotel, Colorado Springs, Nov. 19, 20.

FLORIDA HOSPITAL ASSOCIATION, Miami Beach, Dec. 1, 2.

ILLINOIS HOSPITAL ASSOCIATION, Annual Meeting, Hotel Abraham Lincoln, Springfield, Dec. 1, 2.

ILLINOIS HOSPITAL AUXILIARIES ASSOCIATION, Hotel Leland, Springfield, Dec. 1, 2.

INSTITUTE ON DIETARY DEPARTMENT ADMINISTRATION, Park Sheraton Hotel, New York City, Oct. 26-30.

INSTITUTE ON HOUSEKEEPING, Somerset Hotel, Boston, Nov. 16-20.

INSTITUTE ON LAUNDRY, Park Sheraton Hotel, New York City, Nov. 9-13.

INSTITUTE ON NURSING SERVICE ADMINISTRATION, St. Charles Hotel, New Orleans, Dec. 7-11.

INSTITUTE ON PURCHASING, Penn Sheraton Hotel, Philadelphia, Oct. 19-23.

INSTITUTE ON SUPERVISORY TRAINING, Edgewater Beach Hotel, Chicago, Nov. 2-6.

INTER-AGENCY INSTITUTE FOR FEDERAL HOSPITAL ADMINISTRATORS, Walter Reed Army Medical Center, Washington, D.C., Oct. 26-Nov. 13.

KANSAS HOSPITAL ASSOCIATION, Lassen Hotel, Wichita, Nov. 12, 13.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Lord Baltimore Hotel, Baltimore, Nov. 9, 10.

MISSISSIPPI HOSPITAL ASSOCIATION, Buena Vista, Oct. 14-16.

MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Nov. 19, 20.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Nov. 12, 13.

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 12, 13.

OREGON ASSOCIATION OF HOSPITALS, Hotel Benton, Corvallis, Oct. 22, 23.

1954

AMERICAN HOSPITAL ASSOCIATION, Navy Pier, Chicago, Sept. 19-22.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-13.

IOWA HOSPITAL ASSOCIATION, Annual Meeting, Savery Hotel, Des Moines, April 21.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, Jan. 26.

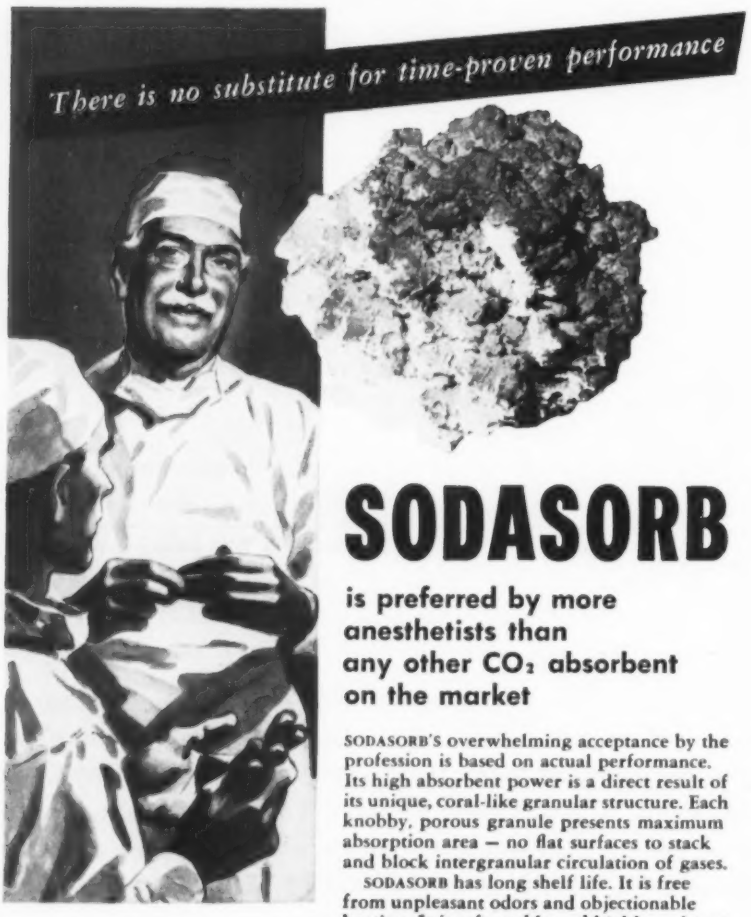
NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, Biennial Congress, Chicago, June 2-5.

OHIO HOSPITAL ASSOCIATION, Hotel Cleveland, Cleveland, Mar. 29-April 1.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 7-9.

TENNESSEE HOSPITAL ASSOCIATION, Hotel Greystone, Gatlinburg, Tenn., May 20-22.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 18-20.



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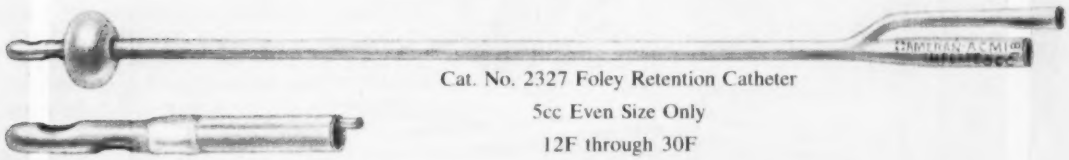
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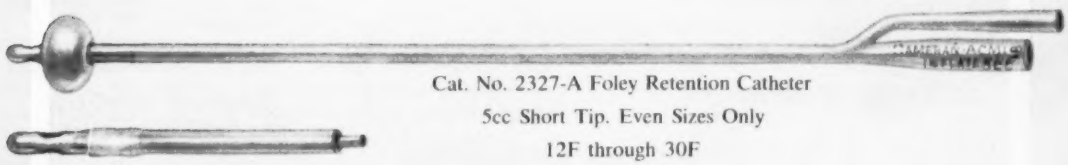
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A. C. M. I.

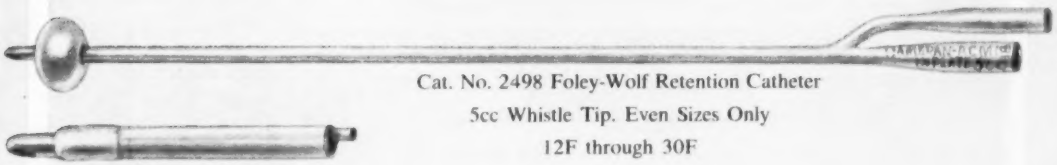
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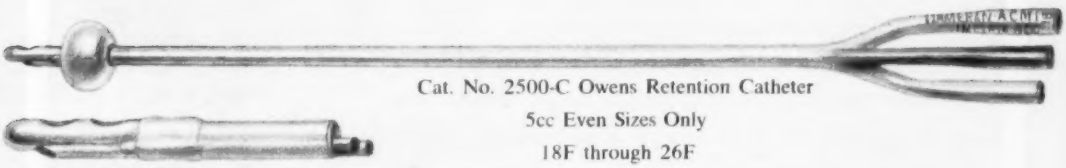
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NEWS...

Michael Reese Sponsors Redevelopment Program

CHICAGO.—Proposals for a 54 acre slum redevelopment program were announced here last month by the Chicago Land Clearance Commission and Michael Reese Hospital, sponsor of the project, whose present site adjoins the area recommended for clearance and redevelopment. Dr. Morris H. Kreeger, executive director of the hospital, and several members of the hospital board were active in sponsoring and planning the redevelopment program, the announcement said.

The hospital has plans to build additional buildings for medical and educational use on some of the redeveloped land, and to add 1000 dwellings on property adjacent to the hospital, the announcement said. Redevelopment will be undertaken in stages over a period of 10 years, the commission indicated.

Danbury Situation Is Settling Down

DANBURY, CONN.—Four new trustees were elected to the board of the Danbury Hospital here last month, filling vacancies created during the board-staff controversy that followed suspension of two positions from the medical staff last October.

The two physicians, Dr. John D. Booth and Dr. Nathaniel B. Selleck, have been reinstated to staff membership.

The four new trustees were also elected to the hospital's board of managers at the meeting last month. The board of managers includes 16 members elected from the 45 member trustee group, it was explained.

Dr. René Sand Dies

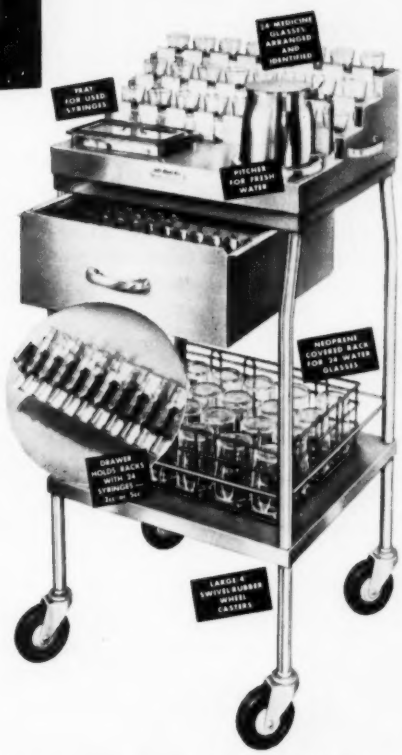


Dr. René Sand

BRUSSELS, BELGIUM.—Dr. René Sand, for many years professor of public health at the University of Brussels, died here last month at the age of 76. Dr. Sand was founder of the International Hospital Federation and had served as its president for a number of years. An outstanding European authority on problems of hospital administration, Dr. Sand was the author of a number

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Medi-Kar Experience-Proved Medication System . . .



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Let the more than 750 hospitals using over 2400 Medi-Kars tell you why they adopted the Medi-Kar, the "Cadillac" of all medication carts, for their nursing service. These leading hospitals found from *experience* — no other medication system offers the practical advantages of safety and convenience for the patients with such great savings in time and work for their nurses!

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of books and articles in the field of social medicine, public health and preventive medicine which were his lifelong interest. Throughout his career, he emphasized the hospital's responsibilities for conducting programs in social and preventive medicine, which he had made the principal theme of the biennial congresses of the International Hospital Federation.

A long-time friend and associate of the late Dr. Otho F. Ball, founder and president of The Modern Hospital Publishing Company, Dr. Sand had been a frequent contributor to The MODERN HOSPITAL over the years. Following Dr. Ball's death last July, he wrote—just a few days before his own death on August 23—to The MODERN HOSPITAL as follows: "The news of Dr. Ball's death has been a great shock to me and is a heavy personal loss. Since I had the pleasure of meeting him for the first time some 30 years ago, he never missed an opportunity to render me a service and to show his sympathy. Everyone interested in hospitals will remember his prominent and constant services."

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Administrator and Board Resign From Chillicothe in Dispute With City

CHILLICOTHE, MO.—Superintendent Frances Fernald and the entire board of the Chillicothe City Hospital resigned their jobs here last month in a disagreement with the city administration over management policies.

In a letter to the city council, the board said the hospital had been operated on a bipartisan basis for years without interference from past city administrations.

"Since you have taken complete control and there is no further need of a board," the board letter to the new city administration continued, "we feel we cannot continue to operate successfully."

According to newspaper reports, the city council had requested that the board and the superintendent consult the council before hiring personnel or raising hospital salaries. The council also requested more frequent financial reports, it was explained.

Asserting that her usefulness as superintendent ended when she was denied the right to hire and fire hospital employes, Mrs. Fernald told the board she could not continue working under conditions established by the new city council. Her resignation, and those of the board members, all businessmen, followed.

Michigan Survey of Costs Indicates Wages Account for 70 Per Cent of Increase

LANSING, MICH.—A statewide survey of hospital costs reveals that wages for hospital employes account for virtually 70 per cent of the increased cost of hospital care, according to a report issued today by the Michigan Hospital Association.

At the same time, its findings indicated that the widespread adoption of prepayment programs like Blue Cross was not a significant factor in the increase in the cost per patient day of 49 per cent between 1947 and 1951.

The survey, begun a year ago at the request of State Insurance Commissioner Joseph A. Navarre, was the first such study that included the possible

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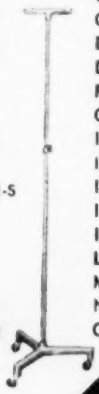
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- Dressing Carriages
- Drum Stands
- Foot Stools
- Glove Racks
- Instrument Cabinets
- Instrument Stands
- Instrument Tables
- Irrigator Stands with Percolator
- Irrigator Stands
- Linen Hampers
- Mayo Stands
- Nurses Work Tables
- Observation Stands

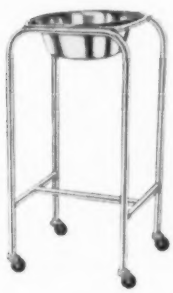
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Stainless Steel
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Kick Bucket
Aluminum
Pritchard Model — No. 3083-A

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Circular Sponge Receptacle
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- Operating Stools
- Operating Tables
- Solution Stands
- Sponge Racks
- Sponge Receptacles
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- Utility Tables
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impact of prepayment programs on hospital costs.

The Michigan Hospital Association sponsored the survey which was made by Arthur Andersen & Co., a Chicago firm of accountants and auditors recommended by Mr. Navarre as competent and impartial.

It covered in detail the cost operations of 10 Blue Cross participating hospitals which represented a cross-section of all Michigan hospitals.

The survey found that between 1947 and 1951 the average cost per patient day rose from $15.33 to $22.88, an increase of $7.55.

Wages and salaries for hospital personnel accounted for $5.15 of that increase, 68.2 per cent.

The report said that about 73 per cent of that increase in pay-roll cost was for higher salary rates and the remaining 27 per cent for additional employes.

However, the survey pointed out that, despite these wage increases, average salaries for hospital employes in 1951 were still considerably below the average for comparable jobs in non-manufacturing industry.

In regard to additional employes, the report said:

"An important factor in the increased number of employes required per patient day was the reduction of the normal work week during the period reviewed by an amount ranging from four to eight hours a week."

The survey found that the second biggest factor in the increase in cost per patient day was supplies, which accounted for 16 per cent of the rise.

Exhaustive comparison of patients' record cards revealed the total case cost of Blue Cross patients to be within 1½ per cent of that of non-Blue Cross patients.

The survey established by its review that there is no apparent relationship between a hospital's cost per patient day and its volume of Blue Cross cases.



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ABOUT PEOPLE

(*Continued From Page 90*)



Arthur L. Stern

Arthur L. Stern is the new assistant director of the Long Island Jewish Hospital, Glen Oaks, L.I., N.Y. Before this appointment Mr. Stern had been senior administrative assistant at the Jewish Hospital of Brooklyn. He is a member of the American Hospital Association.

Sister M. Mechtildis, administrator of St. Francis Hospital, Grand Island, Neb., for the last six years, has been named administrator of St. Francis Hospital, Colorado Springs, Colo. **Sister M. Edwardina,** formerly of St. Joseph Hospital, Omaha, Neb., succeeds Sister Mechtildis.

Walter E. Landgraf, formerly director of planning and research for the Hospital Council of Western Pennsylvania, has accepted an appointment as administrator of the Allegheny General Hospital, Pittsburgh.

Dr. William P. McHugh, medical director of Cambridge City Hospital, Cambridge, Mass., resigned to accept a position as assistant director of Essex County Sanatorium, Middleton, Mass.

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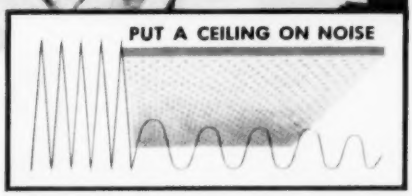
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Beulah J. Burns has resigned as administrator of McCray Memorial Hospital, Kendallville, Ind.

Dr. Rolland R. Gasser, manager of the V.A. Hospital at Framingham, Mass., has been appointed manager of the V.A. Hospital at West Roxbury, Mass.


Douglas M. McNabb

Douglas M. McNabb has been appointed administrator of the Emma L. Bixby Hospital, Adrian, Mich. Mr. McNabb was formerly administrative assistant at Vancouver General Hospital, Vancouver, B.C., where he went upon completion of the course in hospital administration at the University of Toronto. He had been associated with Royal Columbian Hospital, New Westminster, B.C., before attending the university.

John H. Deans, administrative assistant at McLeod Infirmary, Florence, S.C., has been appointed assistant administrator of Conway Hospital, Conway, S.C., effective October 1.

Helen T. Nivison, R.N., administrator of Griffin Hospital, Derby, Conn., has resigned after 31 years with the hospital. **A. J. DeLuca** has been appointed administrator. He assumed his duties October 1. Mr. DeLuca is presently assistant administrator of the Lawrence and Memorial Associated Hospitals in New London, Conn., a position he has held since February 1951. He is a graduate of the course in hospital administration of Columbia University and served his administrative residency at Menorah Hospital Medical Center, Kansas City, Mo., and Mount Sinai Hospital, Cleveland. Mr. DeLuca is a member of the American College of Hospital Administrators and holds memberships in the American Hospital Association, the Connecticut Hospital Association and the American Public Health Association. Miss Nivison, a fellow of the American College of Hospital Administrators, has held many offices in the nursing field, in addition to serving as treasurer of the Connecticut Hospital Association for the last seven years.

Dr. Glen W. Doolen succeeds **Dr. John G. Hood** as manager of the V.A. Hospital at Richmond, Va. Dr. Doolen is presently chief of plans and development in the tuberculosis division of the department of medicine and surgery, Washington, D.C.

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J. W. Myers, administrator of the Fayette Memorial Hospital, Connersville, Ind., since December 1950, resigned to become administrator of Muscatine County Hospital, Muscatine, Iowa.

Lewis A. Kellison is the new administrator of Waynesboro Community Hospital, Waynesboro, Va. Previously he had been assistant administrator of the Rockingham Memorial Hospital, Harrisburg, Va.

D. D. Richards has been appointed business manager of Columbus Hospital, Columbus, Miss., succeeding **Herman Seefeld Jr.,** who has become administrator of the Noxobee General Hospital, Macon, Miss.

W. I. Fender Jr. is the new administrator of the Mary Black Memorial Hospital, Spartanburg, S.C.

Mae Aldrich, superintendent of Houston Tuberculosis Hospital, Houston, Tex., resigned the position she had held since November 1921.

Jack L. Rogers, manager of the John Burns Memorial Hospital at Belle Fourche, S.D., since 1947, has been appointed administrator of Sioux Valley Hospital, Sioux Falls, S.D. Before taking over at Burns Memorial, Mr. Rogers had been assistant to the business manager at the Black Hills General Hospital, Rapid City, S.D.

Lt. Col. Jack D. Burnett, MSC, has been named management officer at Walter Reed Army Medical Center, Washington, D.C. Col. Burnett goes to Walter Reed from the Army Medical Research Laboratory at Fort Knox, Ky., where he served as executive officer.

John M. King resigned as administrator of the Petersburg General Hospital, Petersburg, Va., to accept the position of executive director of the Edgewater Hospital, Chicago. He is a member of the American College of Hospital Administrators and the American Hospital Association.

Charles E. Paul, administrator of Huntington County Hospital, Huntington, Ind., has resigned.

Joel H. Walker, a graduate of the University of Minnesota course in hospital administration, has been appointed assistant administrator of Springfield Hospital, Springfield, Mass.

Dr. Leonard A. Walker has been appointed assistant to the director for research at Menorah Medical Center, Kansas City, Mo. Dr. Walker will continue his duties as assistant director of clinical laboratories and will assume his additional responsibilities as the hospital's research program develops. **Max Shain,** supervisor of the medical records and statistics department at Menorah, has been appointed assistant to the director at Menorah Medical Center.

Joseph L. Zem, for three years business manager of St. Luke's Hospital, San Francisco, has been named administrator of the hospital.

Donald J. Conroy has been appointed assistant director of Pontiac General Hospital, Pontiac, Mich. A graduate of the course in hospital administration of the University of Iowa, Mr. Conroy served two years as administrative resident and assistant to the director of the Morristown Memorial Hospital, Morristown, N.J. Appointed administrative assistant was **Ralph L. Hose.** Mr. Hose served a year as administrative resident at Philadelphia General Hospital, Philadelphia, and was administrator of Tyler Memorial Hospital, Meshoppen, Pa., prior to going to Pontiac.

Dr. William R. Duden, director of the Palo Alto Hospital, Palo Alto, Calif., has resigned. Dr. Duden had been with the hospital for five years.

John T. Rawlings has succeeded

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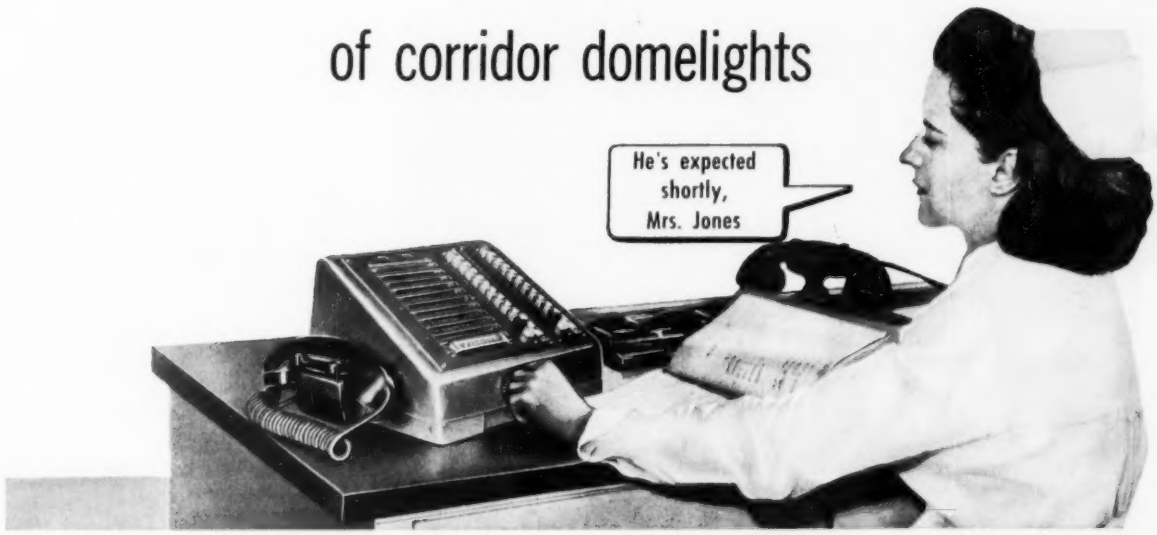


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Dorothy Meldorf as superintendent of Moses Taylor Hospital, Scranton, Pa.

Dr. Earl P. Brannon, chief of professional services at the V.A. Hospital, Perry Point, Md., has been named manager of the hospital. Dr. Brannon, who had been in the private practice of psychiatry, came to the hospital in 1948 as assistant chief of professional services.

Florence Schram, former superintendent of nurses at Boulder County General Hospital, Boulder, Colo., has been appointed manager of the hospital. Mrs. Schram succeeds **David Hutchinson,** who resigned to become superintendent at Boulder Community Hospital, Boulder, Colo. Mrs. Schram has been associated with the County General Hospital for the last eight years—at one time serving as its manager.

John R. Lally, administrator of Ludlow Hospital, Ludlow, Mass., has been appointed administrator of Athol Memorial Hospital, Athol, Mass. Mr. Lally was purchasing agent at Springfield Hospital, Springfield, Mass., before accepting the administratorship at Ludlow. **Frank G. Bisson,** purchasing agent of Springfield Hospital, Springfield, Mass., succeeded Mr. Lally at Ludlow Hospital.

Dr. Linus A. Zink, formerly manager of Mt. Alto Hospital, Washington, D.C., has been appointed acting director of hospitals and clinics in the central office of the Veterans Administration, Washington, D.C. Succeeding him at Mt. Alto is **Dr. Edwin J. Rose,** who had been assistant director of the hospital operations service, V.A., Washington, D.C. Dr. Zink joined the V.A. as clinical director of the hospital at Alexandria, La. In 1949 he was appointed manager of the hospital at Brooklyn, N.Y., and held that position until he was transferred to Mt. Alto in 1952.

Sister Margaret, formerly administrator of Providence Hospital, Waco, Tex., has been named successor to **Sister Berenice,** administrator of O'Connor Hospital, San Jose, Calif., who has been transferred to New Orleans.

Dr. Roger P. Hentz has been named manager of the V.A. Hospital at Northport, L.I., N.Y. Besides managing a number of V.A. hospitals, Dr. Hentz has been assistant director of the program analysis planning section of the psychiatry and neurology division of the Veterans Administration, Washington, D.C.


John C. Ellerbe

John Cheney Ellerbe has been appointed assistant administrator of Orange Memorial Hospital, Orlando, Fla., after completing his administrative residency there. He succeeds **A. G. Pattillo,** who resigned in February. The new assistant administrator is a candidate for a master's degree in hospital administration from Northwestern University.

Dr. Raymond P. Perdue has been appointed medical director of Tucson General Hospital, Tucson, Ariz. He is a graduate of the Des Moines Still College of Osteopathy and Surgery and is a past president of the Michigan Osteopathic Hospital Association. Dr. Perdue organized the Flint Osteopathic Hospital and was president of its board of directors from 1946 to 1952.

Lorraine Holste succeeded **Iona Olson** as administrator of Oxford General Hospital, Oxford, Neb. Miss Olson, who had headed the hospital for two years, left to do postgraduate work at Charity Hospital, New Orleans.

Dr. Duncan D. Campbell has been





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appointed acting superintendent of Chicago State Hospital, succeeding **Dr. Edward F. Dombrowski.** Dr. Campbell has been assistant superintendent since 1946.

Daniel Chapman is acting administrator of Lake Chelan Community Hospital, Chelan, Wash., succeeding **George Preston.** Mr. Chapman was formerly administrator of Phillips County Hospital, Malta, Mont.

Phyllis Goodall has resigned as administrator of Seattle General Hospital, Seattle.

Gruse S. Barton, administrator of John Warner Hospital, Clinton, Ill., has been appointed head of the Harvard Memorial Hospital, Harvard, Ill.

Sister M. Davida, who has recently completed the hospital administration course at St. Louis University, has been appointed administrator of the Sacred Heart Hospital, Manchester, N.H., succeeding **Sister M. Gertrude,** who has been named superior.

Harold Callahan, a former member of the administrative staff of Mary Hitchcock Memorial Hospital, Hanover, N.H., is the new administrator of Henry Heywood Memorial Hospital, Gardner, Mass. He succeeded **Irene McCarthy,** who resigned recently.

Wilma Jones, superintendent of Alma Memorial Hospital, Alma, Neb., resigned recently, and **Joan Smetana,** has accepted the appointment on a temporary basis.

Sister Mary Mercedes, administrator of St. Margaret's Mercy Hospital, Fredonia, Kan., and formerly on the staff at Mercy Hospital, Independence, Kan., has been transferred back to Independence to succeed **Sister Mary Paul,** who has been named superintendent of the new Mercy Hospital at Fort Scott, Kan. Succeeding Sister Mercedes will be **Sister Alberta,** a member of the staff of St. Margaret's since 1950.

Leonard Brown, who has been connected with the Blue Cross in Florida for three years since his retirement from the navy as a hospital lieutenant, is the new general manager of Arcadia General Hospital, Arcadia, Fla.

Frank Eungard, a member of the staff of Morris County Hospital, Council Grove, Kan., for the last year, has accepted the superintendency of Herington Hospital, Herington, Kan.

Walter King, superintendent of Day-Kimball Hospital, Putnam, Conn., has resigned.

Thomas V. Noland, administrator of Claiborne County Hospital, Port Gibson, Miss., has resigned.



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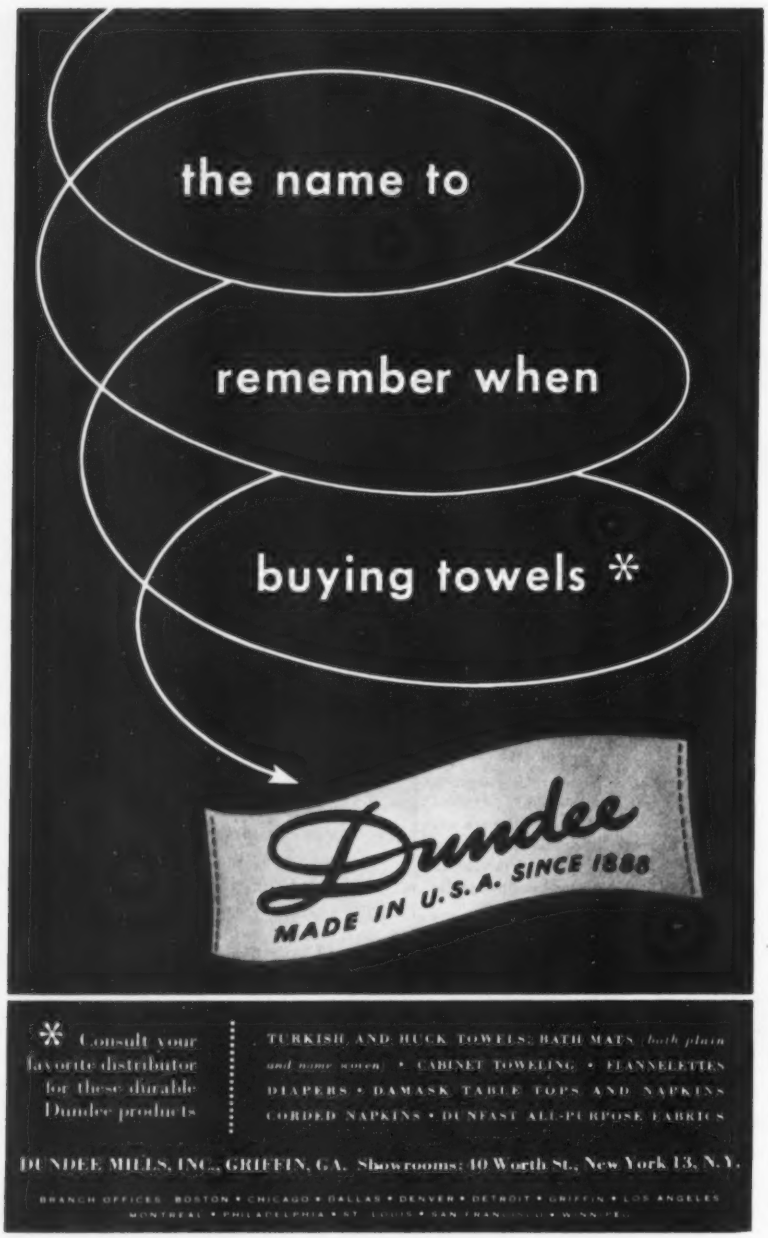
Floyd Grady, administrator of Memorial Hospital, North Platte, Neb., for the last six years has resigned, and a member of the administrative staff of Immanuel Hospital, Omaha, **Paul G. Finnman,** has been appointed his successor.

James F. McLaughlin, assistant superintendent of Conemaugh Valley Memorial Hospital, Johnstown, Pa., has been named administrator of Armstrong County Memorial Hospital, Kittanning, Pa.

Betty L. Carver was succeeded as superintendent of Seidle Memorial Hospital, Mechanicsburg, Pa., by **Cleo Harnish, R.N.,** supervisor of Altoona Hospital, Altoona, Pa., for the last 12 years.

E. Beryl Hoover, superintendent of Nason Hospital, Roaring Spring, Pa., has resigned.

Edward F. Hunter has succeeded **Samuel E. Stewart** as administrator of Muncy Valley Hospital, Muncy, Pa. Mr. Hunter recently completed an administrative residency at Geisinger Hospital, Danville, Pa., and holds a master's degree in hospital administration from Northwestern University.



Department Heads

Dr. David R. Weir, associate professor of medicine at Western Reserve University, has been named director of medical services and chief of medicine at the new Highland View-Cuyahoga County Hospital, Cleveland.

Dr. Jean Spencer Felton has been appointed director of health service of the University of Oklahoma Hospital, Oklahoma City. A specialist in industrial medicine, Dr. Felton has academic appointments in the University of Oklahoma School of Medicine as associate professor in the departments of medicine and preventive medicine and public health. This fall he is establishing the medical school's first course in industrial medicine. Dr. Felton went to Oklahoma City from the Oak Ridge National Laboratory, Oak Ridge, Tenn., after serving there as medical director for seven and a half years.

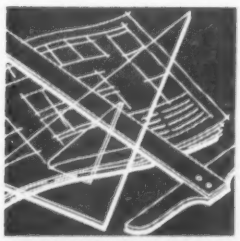
Mary I. Major has been appointed director of nursing at Hawthorne Community Hospital, Hawthorne, Calif., succeeding **Buelah Ree Burtch.** Miss Major is a graduate of Washington University School of Nursing, St. Louis, and received her bachelor of science degree from the same university. Miss Major's experience includes service at Barnes Hospital, St. Louis; American Hospital, Chicago, and California Hospital, Los Angeles.

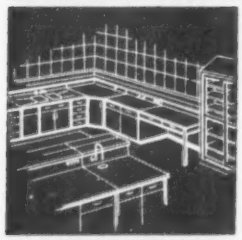
Nicholas G. Fanos, plant superintendent at the Hospital Center, Orange, N.J., for the last two years has resigned to accept a similar position at Jewish Hospital, Cincinnati. Succeeding him at the Hospital Center is **James Holt Jr.,** a graduate of the Massachusetts Institute of Technology, whose experience includes construction work in Alaska.

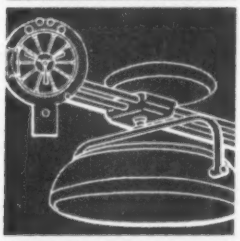

Thelma Laird

Thelma Laird has been named director of nursing of Memorial Center for Cancer and Allied Diseases, New York City, and assumed her duties October 1. While serving in her new capacity, Miss Laird will continue as instructor and field supervisor in nursing education at Teachers College, Columbia University, on a part-time basis. Prior to joining the Teachers College staff in 1952, Miss Laird served four and one-half years as associate executive secretary of the American Nurses Association and earlier as nurse consultant of the Nursing Information Bureau of the Na-

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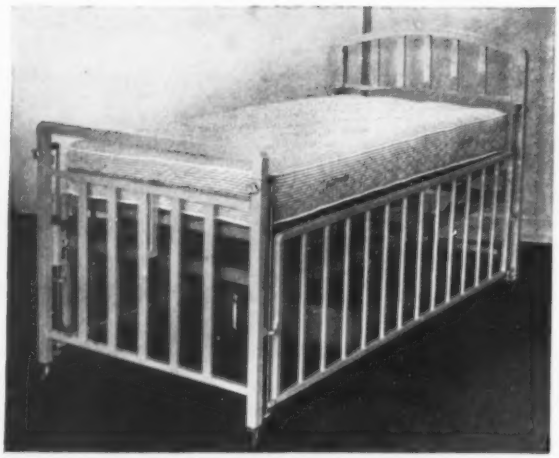
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tional Nursing Associations. She holds a reserve commission of lieutenant-commander in the navy nurse corps.

Miscellaneous

John H. Hayes, director of the Commission on Financing of Hospital Care, has been appointed chairman of the committee on careers of the National League for Nursing. He succeeds **Theresa I. Lynch,** dean of the school of nursing at the University of Pennsylvania, who served as chairman of the committee for more than five years.



Arthur M. Calvin

Arthur M. Calvin, one of the founders of the Minnesota Blue Cross Plan and executive director from 1939 to the present time, was elected president of the Minnesota Hospital Service Association. Prior to his full-time work in Blue Cross he was administrator of Mounds Park and Midway Hospitals in St. Paul from 1925 to 1939. He is a charter member of the American College of Hospital Administrators. The former president of the American Protestant Hospital Association, he has served on various national committees of the American Hospital Association. Mr. Calvin is also executive director of the Blue Shield Plan in Minnesota.

Helen Nahm has been appointed associate director of the National League for Nursing and director of its division of nursing education, succeeding **Julia Miller,** who resigned recently. She has been director of the department of baccalaureate and higher degree programs and of the league's accrediting service; she was also director of the division of nursing education and, earlier, professor of nursing education at Duke University.

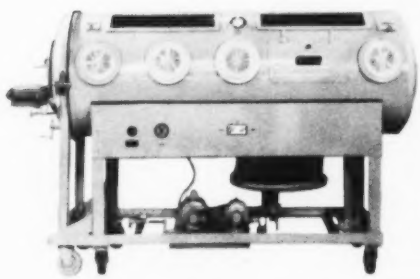
Mary A. Johnson, lieutenant-commander, U.S. Naval Reserve, has been appointed to the faculty of the school of nursing at St. John's University, Brooklyn, N.Y., where she will teach personnel management and hospital administration in the graduate program of the school. She has taught at New York University, University of Maryland and Columbia University. During World War II, Miss Johnson served with the navy's bureau of medicine and surgery as officer in charge of rehabilitation services in U.S. naval hospitals.

Maj. Gen. Paul H. Streit has been appointed area medical administrator of the Johnstown, Pa., office of the United

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Mine Workers Welfare and Retirement Fund, effective early this month. Gen. Streit recently retired from the position of commanding officer of the Army Medical Center and Walter Reed General Hospital, Washington, D.C. He succeeds **Dr. Sterling B. Brinkley,** who will become medical director of the Gaylord Sanatorium at Wallingford, Conn.

Dr. Arthur H. Dearing has been appointed executive secretary of the College of American Pathologists, Chicago, to succeed **Dr. M. G. Westmoreland.** The recently retired rear admiral of the navy took over his new duties on October 1.

Deaths

Dr. Samuel C. Harvey, oustanding surgeon and noted authority on cancer, died in August at the age of 67.

Elsie L. Miller, for 27 years until her retirement in 1949, superintendent of Frankford Hospital, Philadelphia, died several weeks ago at the age of 68.

Eric Mendelsohn, German-born architect who designed Mount Zion Hospital in San Francisco, died September 21 at the age of 66.

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MANUAL OF HOSPITAL MAINTENANCE. *American Hospital Association, Chicago.* 1952.

The purpose of this splendid manual is well stated in the foreword: "...To familiarize hospital executives and hospital boards with some of the maintenance problems of the physical structure; its equipment and appurtenances, and similar matters closely related to the maintenance problem."

The statement, "The hospital's mechanical and electrical fixtures, in fact, might truthfully be said to be among the most diverse and complicated of any building type created by architects and engineers," is one which every administrator and every member of the board of trustees should take to heart. If they all realized this, I am sure that more attention would be paid to systematic routine maintenance of the hospital physical plant. A careful reading of this manual should convince every administrator that he must understand something about the principles and functions of the major items of mechanical, electrical and professional equipment in the hospital.

The statement pointing out that careful maintenance cost records should be kept on all major items of equipment so that decisions can be made as to when it is cheaper to replace a new piece of equipment than to keep the old in operation is one that should be engraved on the mind of every person interested in efficient hospital operation.

I. E. Behrman, administrator of Newark Beth Israel Hospital, Newark, N.J., who wrote Chapter 1 on "General Considerations" displays his background of construction and engineering knowledge and experience. William G. Illinger, administrator of the White Plains Hospital, White Plains, N.Y., has developed an excellent chapter on organization of the maintenance department. In this chapter, under "Administrative Reports," I do not believe that the subject of boiler plant efficiency reports has been sufficiently covered. Records on fuel consumption by month and year-to-date with comparisons for the same period of the previous year mean nothing unless they are accompanied by information on degree days so that a direct comparison of fuel consumption



Belmont Hospital at *height* of fire

What fire? You mean you didn't read about it? How it started by spontaneous combustion — just as do many tragic hospital fires.

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with known temperature conditions can be made. These reports also are of far more value in control of boiler plant efficiency if the administrator receives reports on the number of pounds of water evaporated per pound of fuel plus CO_2 percentages and stack temperature records.

Chapter 3 on "Purchasing, Supplies and Storage" by Burton B. Lovell Jr., Hartford Hospital, Hartford, Conn., is interesting and informative but seems not to give enough importance to having the top administrator of the hospital working with the chief engineer in the selection of major items of engineering equipment, such as pumps, compressors, motors, steam generators, paint and hardware, electrical equipment, and the like. Administrators must know enough about these extremely important items to be able to discuss them intelligently with the engineer and to pass sound judgment on the engineer's recommendation.

Chapter 4 on "Sanitation and Asepsis" by Sam Gilmer, hospital consultant, Division of Hospital Facilities, Public Health Service, is excellent and should be "must" reading by everyone in our field. By and large, too little attention is paid by too many hospitals to the important subject of sanitation in the hospital.

Chapter 5 on "Heat, Light, Power and Water" by T. Joseph Hogan, chief of engineering and maintenance of the Public Health Service hospitals, is perhaps the most complete and valuable chapter in the entire manual. Any administrator reading this excellent chapter will acquire a sound idea of problems involved in the subjects covered. Under the heading of "X-Ray Equipment" in this chapter, I believe that some mention should have been made of the need for absolutely uniform voltages for the x-ray department, which in turn often requires separate transformers serving only the x-ray department.

Leland J. Mamer, superintendent of maintenance of St. Luke's Hospital, New York City, in his coverage of "Building Maintenance—Interior and Exterior" in Chapters 6 and 7 has written a primer of building maintenance which should result in far more efficient work of maintenance departments in many hospitals. Mr. Mamer's treatment of this important subject displays his professional engineering background and his long years of experience in hospital building maintenance.

Chapter 9 by Louis L. Brega, Rhode Island Hospital, Providence, R.I., covering "Special Problems" correctly emphasizes preventive maintenance. His section on fire prevention is splendid and every hospital administrator should check the list of common faults in electrical systems in this chapter.

Not the least valuable part of this splendid manual is the list of suggested readings on hospital maintenance.

The committee is to be congratulated on making a major contribution to hospital literature.

BACKGROUND TO HOSPITAL PLANNING. *By H. W. C. Vines. M.D. London: Faber and Faber, Ltd.,* 1952. *Pp.* 188.

In Chapter 1 on introducing the hospital, Dr. Vines, who is professor of pathology at the University of London, expresses his dissatisfaction with doctors and architects in England because both groups are bound too closely by traditional patterns. He states, "There is always the danger that chronic traditionalism will, in the course of time, build up a wall of instant prejudice against anything new." The au-

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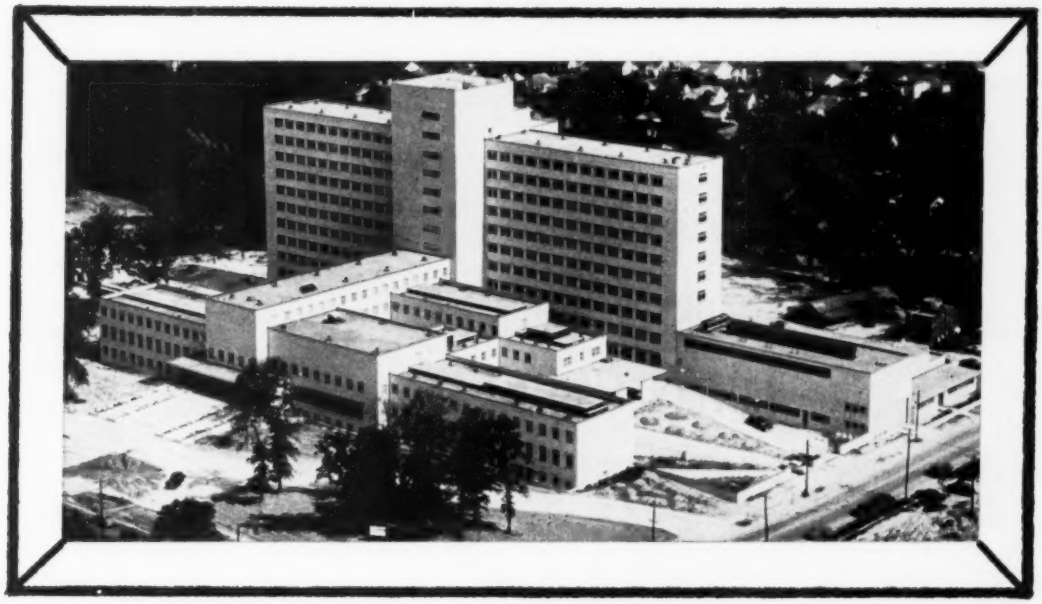
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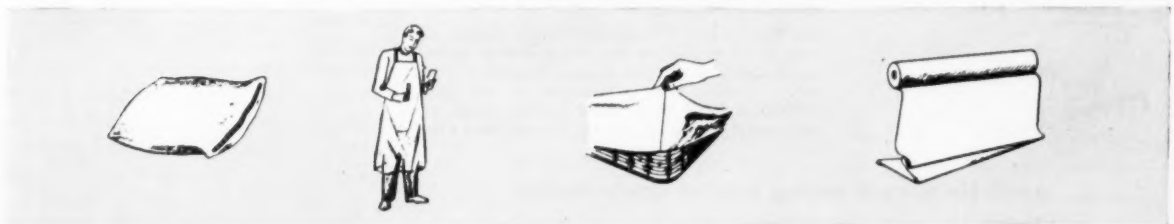
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thor is somewhat critical of people who are constantly trying to make hospitals homelike. He says, "But whose home? Should they be like the pre-fab, the tenement, the middle class suburbia or the stately homes of the so-called wealthy?" A hospital must create its own atmosphere, Dr. Vines says, and not try to ape something which it is not and never can be.

Chapter 2 covers the "Functions of an Acute Hospital." Dr. Vines emphasizes the importance of educating all members of the hospital team, including the medical staff, on the subject of human relations, which, he says, is largely composed of toleration, forebearance and good sense. In discussing the size of hospitals, Dr. Vines points out many of the difficulties which arise when a hospital's capacity is larger than a thousand beds. His conclusion is that an 800 bed hospital is about right and that probably the lower limit of an acute general hospital should be about 200 beds. Great emphasis is placed on the importance of flexibility so that, as the years go on and needs change, the large areas of the floor space can easily be stripped down and replanned for quite different uses. Dr. Vines jumps right into the middle of the controversy between architects who favor large expansive areas of glass and those who do not by stating, "In any case, the sick human being like other sick animals dislikes bright light and large expanses of south-facing glass." This feature, he says, is far less popular with patients than it is with the hale and hardy architect who views this type of hospital with so much pride.

The author points out with great clarity the importance of using professional nurses for professional functions only. He seems to agree entirely with the latest thinking on this question in the United States. Dr. Vines emphasizes a thing which so often is forgotten in this country and that is the possibility of the great fuel savings through the use of double-glazed windows. He does not emphasize, however, the importance of properly calking the window frames and of using weather stripping on doors and windows. Great emphasis is placed by the author on the time saving value and the patient assurance and well-being value of nurse-to-patient voice communication systems. In discussing this, however, he fails to call attention to one important point, which is the use of nursing-unit clerks through a considerable portion of the day and early evening periods, so that the calls from patients over this system can be promptly handled. He also might have shown the great saving of professional nurses' time through the use of these nursing-unit clerks. In discussing food service and food waste disposal, the author apparently is not familiar with modern garbage grinders, centralized food service and other mechanical aids in general use in the United States.

Dr. Vines emphasizes the importance of a good health service setup for hospital employes so that these people can be kept in a healthy, happy state and thus give better care to patients. The chapters devoted to the care of outpatients and the general care of inpatients are most interesting and well worth reading.

Professor Vines, in his treatment of all phases of hospital planning, emphasizes the importance of cooperative thinking and planning between the medical staff, the architect, and the administrative officers of the hospital. I found the approach to hospital planning by a medical professor most unusual and interesting.—E. W. JONES.

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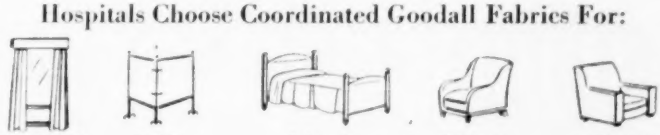
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HEALTH MANPOWER SOURCE BOOK, Section 2: Nursing Personnel. *U.S. Department of Health, Education and Welfare, Public Health Service, Division of Nursing Resources and Division of Public Health Methods. Washington, D.C.* $0.40.

This 88 page booklet is a comprehensive compilation of information on the nation's nurse supply, including enrollment in schools of nursing, graduation statistics, job characteristics, and educational status of professional and practical nurses, and information on nurse licensure and employment by states. The information presented covers a period of 50 years and is presented largely in tabular form.

The section on hospital nursing makes note of the fact that the number of professional nurses in hospitals, including private duty nurses, increased 68 per cent from 1944 to 1951, while the number of nonprofessional nursing workers in hospitals increased 55 per cent in the same period. In October 1951, it is indicated, the two groups totaled 519,000 personnel employed in hospitals; 248,000 were professional nurses.

Commenting on the new publication, Surgeon-General Leonard A. Scheele of the Public Health Service said, "General hospitals employ four times as many nurses per patient today as in 1938. However, nursing technics are becoming more numerous, more complex, and more time-consuming as medicine and surgery advance. Present standards of medical practice demand many additional nurses to provide all the care hospital patients require."

Copies of the source book may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D.C.

New Miami Valley Hospital Dedicated in Dayton, Ohio

DAYTON, OHIO.—The new, eight-story Miami Valley Hospital was dedicated last month at public ceremonies with Charles Kettering, scientist and former General Motors research director, as the principal speaker.

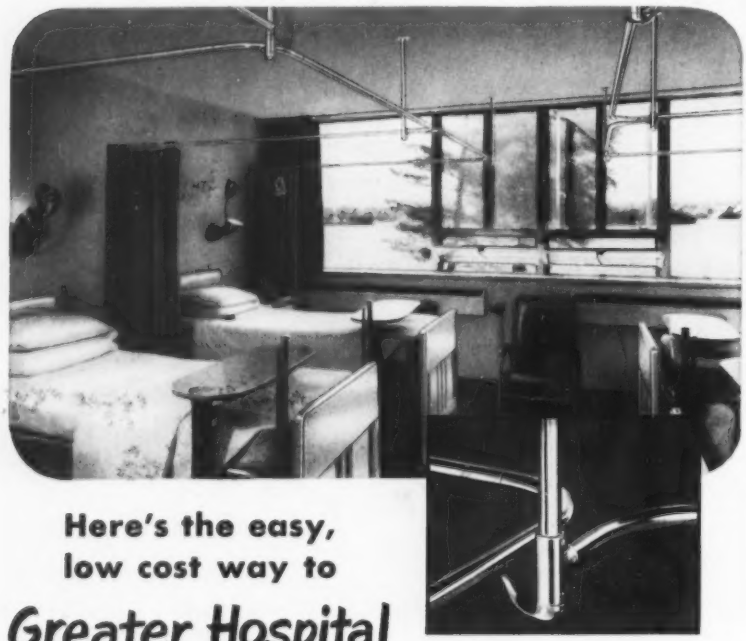
Built entirely with the gifts of private citizens and corporations, without government aid or subsidy, the hospital was described by its president, Attorney Irvin Bieser, as "this community's answer to the oft-heard charge that private initiative is wanting and that government supervision of health services is needed."

The new hospital will provide nearly 200 additional and badly needed hospital beds for Dayton and the Miami Valley area when it is in complete readiness to receive patients in 60 to 90 days, a hospital announcement said. Administrative and nursing staff members already are occupying their offices in the new structure, which was started in 1950 and was more than 95 per cent completed September 1.

Dedication ceremonies were followed by open house tours of the building and special events during dedication week, featuring programs for nursing personnel, physicians and surgeons, hospital personnel, volunteers and the clergy of the greater Dayton area.

Most patient accommodations in the new hospital are found on the third, fourth, fifth and sixth floors.

Remodeling of the surgical building adjacent to the new hospital for maternity use will provide 107 additional beds and 92 bassinets, making available a total of 830 beds and bassinets. Total cost of the new hospital and of the modernization program will exceed $8,000,000.



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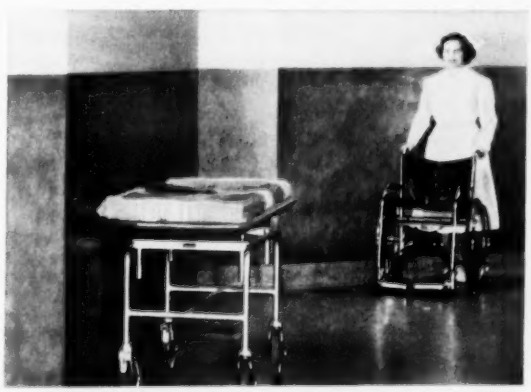
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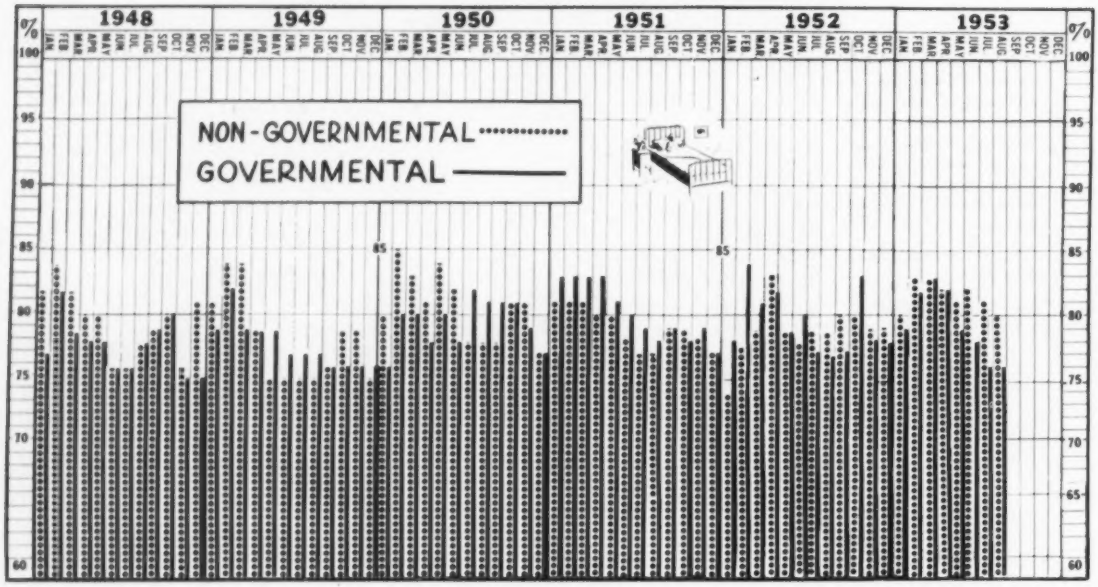


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New hospital construction for the period August 24 through September 21 totaled $64,518,818—bringing the total for the year to $563,247,323. For the comparable August-September period last year, construction totaled $67,642,521. During the first nine months of last year, construction aggregated $460,048,632. Of the 75 projects reported for the current period, 48 were additions and 19 were new hospitals.

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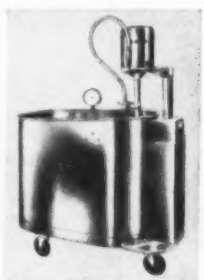
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**Currence, J. D., N. Y. State J. of Med. 48:2044, 1948.

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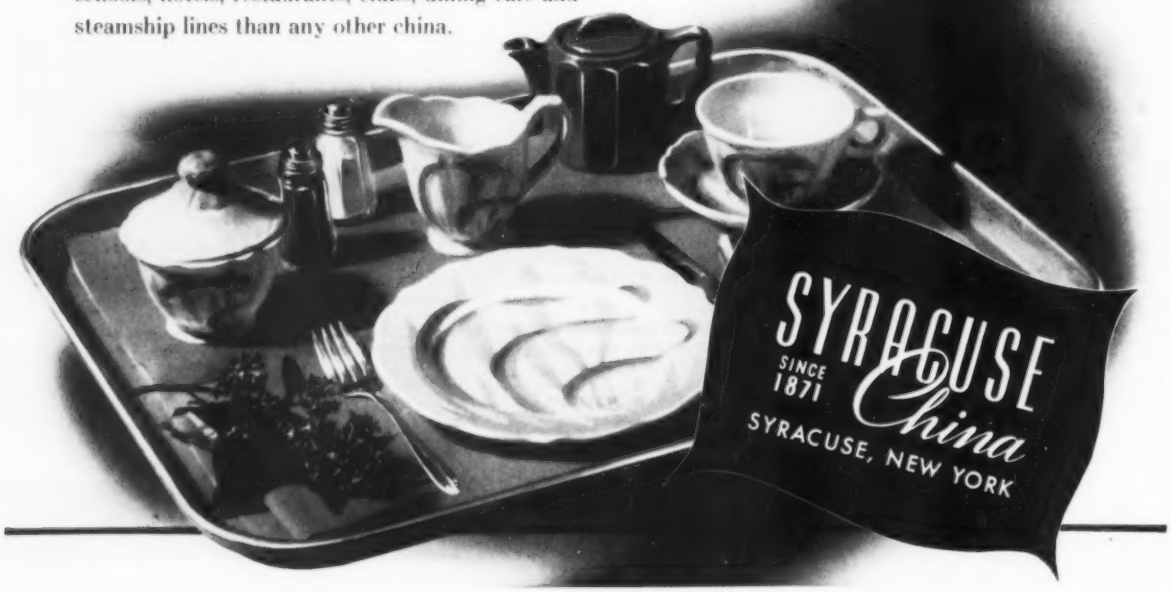
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BIOCHEMIST—Ph.D., three years' teaching; four years, biochemist and assistant director laboratories, 400-bed hospital.

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PATHOLOGIST—32; 4F; Diplomate, pathological anatomy, clinical pathology; trained important large hospital; 3 years, postgraduate, pathology, Mayo Foundation; unusually well trained young pathologist.

PATHOLOGIST—Diplomate, pathologic anatomy, clinical pathology; 7 years, department director, university hospital and on faculty medical school.

PERSONNEL DIRECTOR—31; B.A., teacher's college; past 3 years, assistant personnel director, 3000-bed hospital; seeks directorship, personnel, large hospital; will consider assistant.

PHARMACIST—Ph.C., one of leading universities; 12 years, chief pharmacist, university hospital; currently instructor and supervising pharmacist, university college of pharmacy; interested only in appointment as chief with very large hospital.

RADIOLOGIST—Diplomate, therapy and diagnosis; well qualified, oncology (malignant) and isotopic medicine; past 6 years, assistant radiologist, large hospital and faculty member, leading medical school; prefers Middle Atlantic states or New England; draft exempt; ACR; ASCP; age 38.

SECRETARY, EXECUTIVE — Correspondent, supervisor of 15 secretaries, large teaching hospital social service background; experienced bookkeeper.

(Continued on page 226)

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NURSE SUPERINTENDENT—Prefers central states; highly recommended; 15 years, 50-85 bed hospitals; completed building project, last position.

POSITIONS OPEN

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ANESTHETIST—Nurse; for 250-bed hospital, well equipped and fully approved, predominantly surgery; top salary, meals and laundry furnished; good hours; sick leave, vacation and holidays. Apply, Administrator, Mid State Baptist Hospital, Nashville, Tennessee.

ANESTHETIST — Nurse; modern 115-bed, acute general hospital; department in charge of certified medical anesthetist; salary open. For particulars, write Director, Department of Anesthesiology, Mount Sinai Hospital, Hartford, Connecticut.

ANESTHETIST—Nurse; for an old established group; good starting salary and permanent position. The Sugg Clinic, Ada, Oklahoma.

ANESTHETIST—Nurse; needed by a 200-bed general hospital; air-conditioned surgery; pleasant environment; service not heavy; salary open. If interested, contact Administrator, Washington County General Hospital, Greenville, Mississippi.

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ANESTHETIST — Registered nurse; 135-bed modern general hospital, including professional building accommodating twenty specialists in the various fields of medicine and surgery; situated in nice section of Detroit; good remuneration. Willis J. Gray, Director, Jennings Memorial Hospital, 7815 East Jefferson Avenue, Detroit 14, Michigan.

ANESTHETIST—Nurse; for 150-bed general hospital; 40-hour week; extra pay for call duty; four weeks' vacation plus six holidays; salary open. Memorial Hospital, Roxborough, Philadelphia 28, Pennsylvania.

ANESTHETIST—A.A.N.A. member; 250-bed general hospital; salary open; automatic increases; laundry provided; 40-hour week; no obstetrics; liberal vacation and personnel policy; social security. Sutter Hospital, Sacramento, California.

ANESTHETIST—Registered nurse; wanted for 168-bed general hospital which is A.M.A. and A.C.S. approved; on call one night out of three and one week-end out of three. Write, Administrator, Franklin Square Hospital, Fayette and Calhoun Streets, Baltimore 23, Maryland.

ANESTHETIST—Nurse; for approved pediatric hospital. Write, Administrator, Milwaukee Children's Hospital, 721 North 17th Street, Milwaukee 3, Wisconsin.

ANESTHETIST—Nurse; 60-bed general hospital; new building, modern equipment; western Wisconsin, college town; vacation, sick leave, retirement plan. Apply to H. C. Guntner, Manager, Memorial Hospital, Menomonie, Wisconsin.

ANESTHETIST—Registered nurse with three or more years experience; salary $461.50; laundry furnished; 40-hour week; 2-week vacation, 12 days sick leave, 7 paid holidays annually; anesthesiologist in department; 200-bed hospital. Apply, Personnel Director, Pontiac General Hospital, Pontiac, Michigan.

ANESTHETIST—Nurse; for 75-bed approved hospital in college town; salary open, depending on qualifications and experience; maintenance in nurses home if desired. Write or call, Superintendent, Central Michigan Community Hospital, Mt. Pleasant, Michigan.

ANESTHETIST—Nurse; wanted for 65-bed hospital, well equipped; 155 miles north of Milwaukee, lovely vacation land; cooperative medical staff and personnel; $450 a month, starting salary, with partial maintenance, Blue Cross hospital insurance and social security. Write, Shawano Municipal Hospital, Shawano, Wisconsin.

ANESTHETISTS—Nurse; for approved general hospital; good personnel policies; full maintenance; vacation; attractive salary; exceptionally good working conditions. Apply: Administrator, Randolph Hospital, Inc., Asheboro, North Carolina.

ANESTHETISTS—Nurse; for 500-bed university teaching hospital; starting salary $383 per month; stated increases; vacation and holiday leave; cumulative sick leave. Apply: Anesthesiologist in Charge, University of Virginia Hospital, Charlottesville, Virginia.

DIETITIAN — Therapeutic, teaching; ADA, experienced preferred; for 400-bed hospital, teaching nutrition and diet therapy; one class annually averaging 40 students; salary commensurate with training and experience; four weeks vacation; sickness benefits, retirement plan, social security; forty-hour week, every other Saturday and Sunday off. Apply, Director of Dietetics, Rochester General Hospital, 501 West Main Street, Rochester 8, New York.

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(Continued on page 228)

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DIETITIAN — Associate, with minimum of three years' experience in administrative and therapeutic dietetics; immediate opening in 200-bed general hospital located in suburban town close to Chicago; $350 per month, plus complete maintenance for ADA member. Write full particulars about yourself to Miss M. Schoeneick, Memorial Hospital, Elmhurst, Illinois.

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DIETITIAN—Therapeutic; 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIAN—Head (administrative); $5130-$5811 per year; to plan, coordinate overall dietary activities of municipal hospitals in a centralized staff capacity; 40-hour week; liberal vacation, sick leave and pension provisions. Write: Detroit Civil Service Commission, 735 Randolph Street, Detroit 26, Michigan.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 2 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIRECTOR OF NURSES—Assistant; in a 441-bed institution located in Delaware; Degree in Nursing Education required; salary depends upon qualifications and experience; maintenance and apartment included. Apply to Director of Nurses, Delaware Hospital, Wilmington, Delaware.

DIRECTOR OF NURSES—100-bed general hospital; degree required; salary depends upon qualifications and experience; pleasant colonial American town of 6000 population; social security; liberal personnel policy. Apply: Executive Director, Kent General Hospital, Dover, Delaware.

DIRECTOR OF NURSING AND PRINCIPAL OF THE SCHOOL OF NURSING—Applications are invited for this position by Royal Columbian Hospital, New Westminster; 432 beds; duties consist of directing nursing services and accredited school of nursing of approximately 175 students; teaching and administrative experience required; prefer minimum of five years as director or assistant director experience; excellent remuneration. Please reply fully giving details of nationality, training, experience, age, etc., to Secretary, Board of Directors, Royal Columbian Hospital, New Westminster, British Columbia, Canada.

DIRECTOR OF NURSING SERVICE—Assistant; for Good Samaritan's Episcopal sponsored hospital of 400 beds; salary open; degree and experience required; excellent personnel policies. Apply, Director of Nursing, Good Samaritan Hospital, Portland 10, Oregon.

DIRECTOR, SCHOOL OF NURSING—School of 75-85 students; class admitted annually; three affiliations: psychiatry, tuberculosis and pediatrics; full accreditation by National Nursing Accrediting Service; M.S. preferred, B.S. considered; experienced; 44-hour week; 6 holidays, 30 days vacation annually; social security; Blue Cross and Blue Shield; salary open for negotiation; 250-bed, voluntary, general hospital. Apply to L. C. Pullen, Jr., Administrator, Decatur and Macon County Hospital, Decatur, Illinois.

INSTRUCTOR—Clinical; for medical and surgical nursing; degree and experience required. The Toledo Hospital School of Nursing, North Cove Boulevard, Toledo 6, Ohio.

INSTRUCTOR—Clinical, in operating rooms; responsible for teaching student nurses and surgical technicians; experience and B.S. Degree or postgraduate courses required; salary commensurate with education and experience; also openings for General staff nurses. Reply, MO52, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 230)

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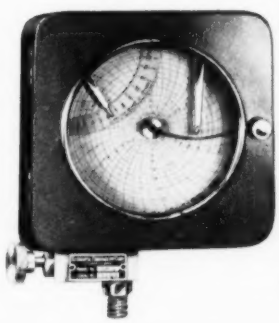
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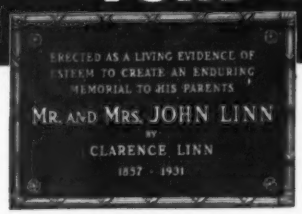


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INSTRUCTORS—Nursing arts instructor and Clinical instructor; 225-bed hospital; 90 students, 3-year course; 36 students admitted each year; insurance plan; social security; liberal vacation; degree required; salary arrangements open for negotiation; travel allowance. Apply Director Nursing Education, or Administrator, Bismarck Hospital, Bismarck, North Dakota.

MISCELLANEOUS—Supervisor of nurses; Laboratory technician; for the Hershey Hospital, Hershey, Pennsylvania; full maintenance, hospitalization, insurance and social security; good salary. Write or apply in person to Dr. H. H. Hostetter, Superintendent of hospital.

NURSE—Registered; for 25-bed hospital; good pay; excellent working conditions; experience in operating room desirable. Broken Arrow Hospital, Broken Arrow, Oklahoma.

NURSES—Staff and operating room; 5 days, 40 hours; 8 holidays and vacation with pay; initial salary $250 plus laundry; increases at 6, 12, 24, 36 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—General duty and Relief; 40-bed acute and convalescent polio and crippled children's unit connected with 200-bed general hospital; 40-hour week; good personnel policy; starting salary $220 to $230 per month. Apply, Supervisor, Polio Cottage, Burge Hospital, Springfield, Missouri.

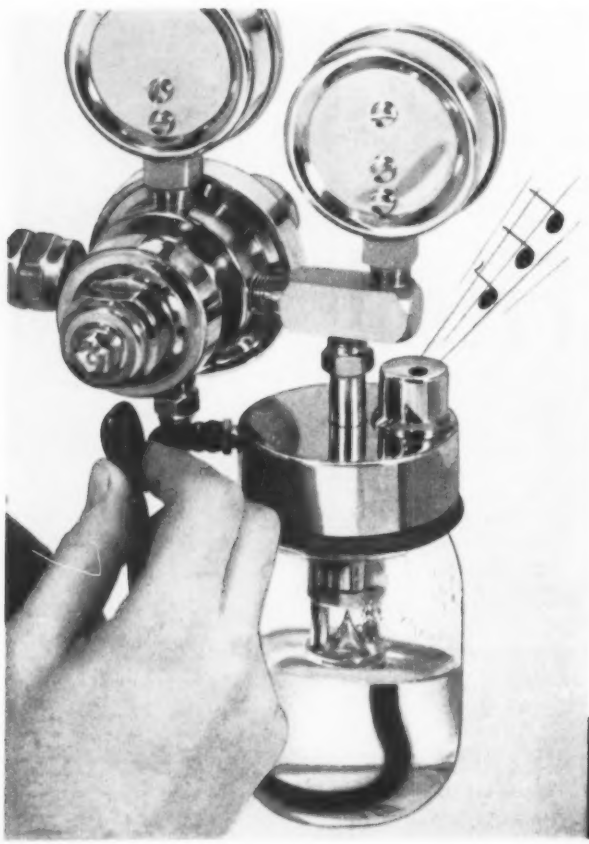
NURSES—General duty and surgical; yearly increments; accumulative sick leave, annual vacation, plus twelve legal holidays a year; salary plus maintenance; one hour from midtown New York. Apply, Director of Nurses, Valley View Sanatorium, Paterson, New Jersey.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES Registered, staff; for 7-3:30 and 3-11:30 in a pediatric hospital for surgical, medical floors and operating rooms; 40-hour week; liberal personnel policies. Apply, Director of Nursing, Babies' Hospital-Coit Memorial, 15 Roseville Avenue, Newark, New Jersey.

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(Continued on page 232)



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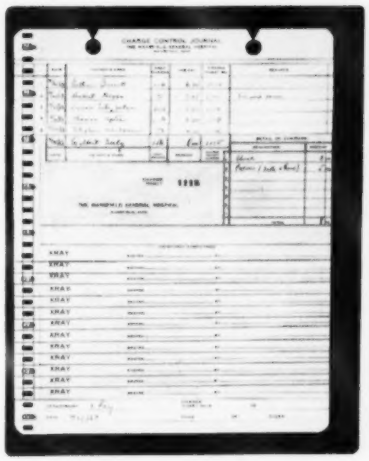
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SUPERVISOR—Operating room; 250-bed hospital with a school of nursing; salary open; supervisory experience and postgraduate work required. Apply, Director of Nursing Service, Mound Park Hospital, St. Petersburg, Florida.

SUPERVISOR—Obstetrical; for 150-bed approved general hospital in beautiful Midland Empire section of Montana near Yellowstone; active obstetrical service; collegiate school of nursing—full national accreditation; Bachelor's Degree and postgraduate course essential; good salary; 40-hour week, paid vacation, social security, hospitalization plan; position open now. Apply to Director of Nursing, Billings Deaconess Hospital, Billings, Montana.

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TECHNICIAN—Laboratory; to complete staff of three in 100-bed hospital; good hours with full maintenance; salary open. Apply, Administrator, Stanly County Hospital, Albemarle, North Carolina.

TECHNICIANS—For general laboratory work; in 338-bed hospital; salary dependent on qualifications. Apply: Pathologist, York Hospital, York, Pennsylvania.

(Continued on page 234)

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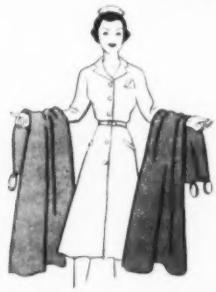
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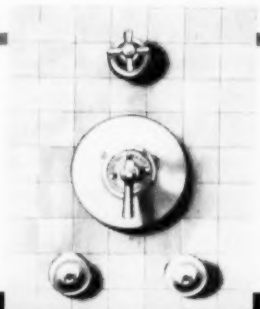
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"Ask any of us old timers in this business, and you'll standardize on Velvet Rainbow Starch too!"

VELVET RAINBOW® STARCH
The starch that keeps things fresh and comfortable longer
THE HURON MILLING CO., 9 Park Place, New York 7, N. Y.

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

ADMINISTRATORS—NURSES. (a) Voluntary, general hospital, 65 beds; college town, near university center, midsouth. (b) General hospital, 125 beds, operated by important industrial company; South America. (c) Convalescent hospital for crippled children; medical school affiliation; university city, south. (d) New 100-bed pediatric hospital; university center; midwest. MH10-2

ANESTHETISTS—(a) Two; large general hospital; 40-hour week; $400-$500; New England. (b) Modern general hospital, 100 beds; college town, midwest; $6000, maintenance. (c) Foreign operations, large industrial company; $8100 which includes living allowance. (d) Association, 10-man group. Diplomates or eligible; college town; $600. (e) New hospital, fairly large size; large city, Pacific coast; $500. MH10-3

DIETITIANS—(a) Chief; voluntary general hospital, 450 beds; attractive location, east; minimum $5000, maintenance. (b) Fairly large general hospital; Pacific Islands. (c) Therapeutic and assistant dietitians; large teaching hospital; new dietary department; university city, south. (d) Direct high school cafeteria; university city; midwest; $600. (e) Therapeutic and assistants; 375-bed hospital affiliated with eminently successful group; $350, maintenance; east. (f) Voluntary general hospital, 300 beds, currently under construction; department staff of 26; Pacific coast. MH10-4

DIRECTORS OF NURSES—(a) Voluntary general hospital, 400 beds; university affiliation; east. (b) General 475-bed hospital; 170 students; all departments well staffed; interesting city outside continental United States; although tropical country, mild pleasant climate. (c) Voluntary general hospital, 500 beds; teaching affiliations; 200 students; five-year course; university center, midwest. (d) New hospital, affiliated medical school; west. (e) Nursing service only; university medical center, newly created appointment; midwest. (f) Nursing service; 600-bed university hospital; although independent administratively from school, highest cooperation between school and service; substantial salary, private apartment; east. (g) Nursing service; new hospital, 325 beds; Pacific coast. MH10-5

EXECUTIVE PERSONNEL—(a) Public relations director; fairly large general hospital; attractive city, outside continental United States. (b) Personnel director, 600-bed teaching center, expansion program; east; $8000. (c) Purchasing agent; general hospital, 225 beds; university city, southwest. (d) Chief comptroller; voluntary general hospital, 400 beds; expansion program; $8500. (e) Purchasing agent; large teaching hospital; university medical center, east. (f) Business manager; new hospital, 125 beds; suburban location, east. MH10-6

FACULTY APPOINTMENTS—(a) Chairman, university nursing education department currently being instituted; qualified faculty in sciences, humanities, general education will contribute to program; up to $9000. (b) Assistant professors in neuropsychiatric, obstetrical, medical, surgical nursing; four-year program; leading university. (c) Assistant professor; state college; program designed to prepare nurses for teaching and health education; Pacific coast. (d) Educational director; children's hospital; outside United States. (e) Nursing arts and clinical instructors university school; faculty rank; Pacific coast. (f) Clinical instructor, pediatries; leading hospital; California; $400. (g) Educational director qualified psychiatric nursing; university school; outside United States; tropical country, mild climate. MH10-7

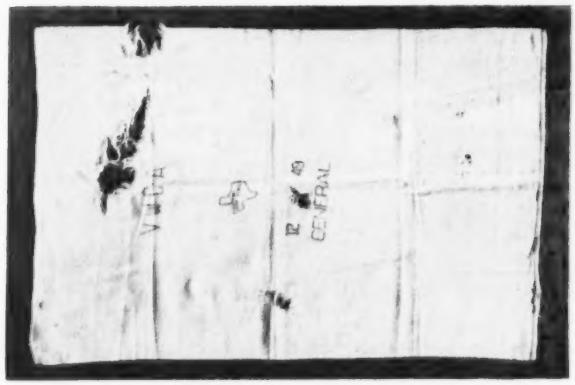
RECORD LIBRARIANS—(a) Chief; 12-man group; Diplomates or Board eligible; California. (b) Chief; large general hospital affiliated medical school; department staff of fifty; south. (c) Chief; fairly large hospital, one of leading in California; capable organizer required. (d) To serve as consulting record librarian to five hospitals, 30-100 beds, within radius of 85 miles; $500. MH10-8

(Continued on page 236)



THE COCA-COLA COMPANY

This picture tells the story



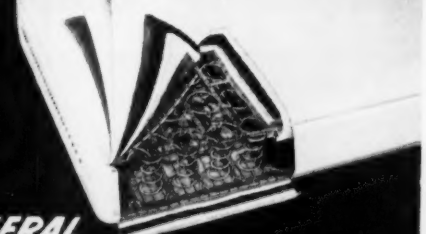
This towel was marked on the edges with transfers and "no heat" inks. The center was marked in 3 places with Applegate Silver Base Ink. After over 200 washings, this unretouched photo speaks for itself. Learn more about our Silver Base Ink that lasts life of fabrics, eliminates labor costs of re-marking.

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REST-RITE has developed a completely new kind of Innerspring General Hospital Mattress which saves an average of 75% of your investment during 10 years. The miracle "Syko" covering used on these mattresses makes possible this great economy. Made in all sizes.

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• "There's all the difference in the world in our uniforms these last two weeks. Stiff as a board they used to be . . . remember, Gloria?"

"It's that new laundry operator. That's the one . . . cute all right, but married. I told him, too. It's a pleasure, I said, these uniforms are actually comfortable. It's the starch he told me. I forget the name. Something with a "rainbow" in it. Oh darn, there's my bell."

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

STAFF AND SURGICAL NURSES—(a) New hospital, 350 beds, affiliated medical school; staff of 75 Board men, 125 residents; university city, midwest. (b) Surgical nurse; small hospital; southwest; $390, maintenance. (c) New hospital, foreign operations; large company; $570 which includes living allowance. (d) Insulin nurse; psychiatric department; new hospital, 250 beds; college town; southwest. MH10-9

SUPERVISORS—(a) Director, new respiratory center affiliated university; services to acute and convalescent polio patients; midwest. (b) Operating room; 400-bed hospital; considerable experience, teaching ability required; $5900-$6500. (c) Pediatric; 40-bed department, 300-bed hospital; college town, Pacific northwest. (d) Psychiatric; new department; teaching hospital; south. (e) Gynecology; large teaching hospital; opportunity continuing studies; minimum, $350. (f) Operating room; small general hospital; residential town, southern California, $350 increasing to $450-$500. (g) Assistant director, operating room; 700-bed teaching hospital; east. (h) Evening, obstetrical, psychiatric, pediatric and operating room supervisors; teaching hospital; attractive location; south; $4000-$5000. MH10-10



OUR 57th YEAR
WOODWARD
Medical Personnel Bureau
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CHICAGO • 1
• ANN WOODWARD • *Director*

ADMINISTRATORS—(a) General hospital, 130 beds; delightful town near coast; California. (b) Lay; assistant; general voluntary hospital, 100 beds; California. (c) General voluntary hospital, 140 beds; excellent Board; teaching program; college town, 100,000; midwest. (d) Medical; important philanthropic organization; to improve hospital care in large number of affiliated hospitals; east. (e) Lay; general hospital, 350 beds; south. (f) Medical; to supervise teaching program; general voluntary hospital, 300 beds; New England. (g) Lay; new hospital, 140 beds; midwest. (h) Lay; general voluntary hospital, fairly large size; require experienced man; east. (i) Medical; one of East's most important teaching hospitals; large size; highly recommended.

ADMINISTRATIVE POSTS—(b) Business manager; experienced with mechanical bookkeeping systems; general voluntary hospital, 150 beds; California. (c) Combined admitting officer and credit manager, new post; general voluntary hospital, 215 beds expanding to 450; midwest. (d) Comptroller; excellent general hospital; medical school affiliated; must be experienced in hospital procedures; $8500; east.

WOODWARD—*Continued*

ANESTHETISTS—(a) Hawaii calls, 390-bed hospital on lovely Hilo Bay; $4800, full maintenance available for only $42.50 month. (b) $7200; 15-man clinic, lovely college town; midwest. (c) 172-bed hospital, church affiliated; two needed, one obstetrical, one operating room; 40-hour week; choice of days off. (d) Small hospital, voluntary general; excellent working conditions, lovely Pacific Northwest town, 3000. (e) New ultramodern 200-bed hospital; 3 anesthetists; 40-hour week, one week-end call a month.

DIETITIANS—(a) Chief; 180-bed hospital, tuberculosis, will expand to 300 beds; new equipment; may reorganize entire department to suit self; on Delaware river; $5400 plus maintenance; also need one assistant, $4800 and maintenance. (b) Chief; 200-bed general hospital; all new modern kitchen, employee cafeteria; southeast Massachusetts; $4500; 2-room apartment; 2 weeks sick leave, 4 weeks vacation. (c) Chief; 104-bed hospital; received award for most beautiful and modern kitchen; A.D.A. registered; midwest resort town. (d) Two required; assistant administrative and therapeutic; general hospital, 243 beds; modern department; hospital only 1 year old; near Detroit; $5100; $4800. (e) Chief; some teaching; Texas town 100,000; 280-bed hospital; new building; meals and laundry furnished; $3800.

DIRECTORS OF NURSES—(a) General, 150-bed hospital; midwest on Fox River, town 18,000; $7000. (b) Voluntary general hospital, 170 beds; nursing school; college town near New York City; $5000, plus meals and apart-

(Continued on page 238)

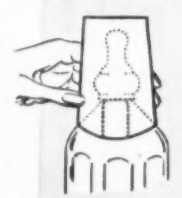
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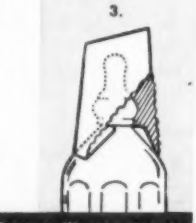
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Does not jar off . . . no breakage. Used extensively by hospitals requiring terminal sterilization. Professional samples on request. Order through your hospital supply dealer.

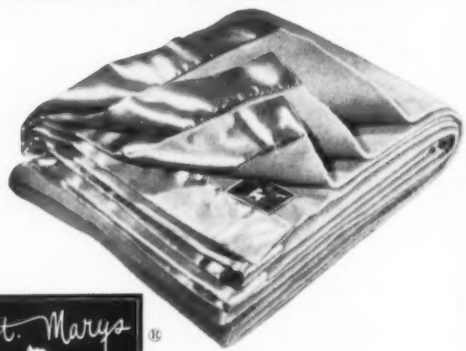
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No. 814 (Won't Tear), the most durable type of unsupported heavyweight Vinylite sheeting. Highly resistant to moisture absorption. Soft and flexible. Won't crack or stick whether wet or dry. Guaranteed flameproof. Will stand sterilization and every other test of Federal specifications ZZ-311A. Maroon . . . .015 thickness. 36", 45" and 54" widths. 25 yd. rolls.

No. 815 Same as above . . . in .010 thickness . . . 25 yd. rolls.

TOP QUALITY *at a LOW PRICE!*
ALL RUBBER (Non Fabric) SHEETING

This non-fabric all-rubber sheeting is completely waterproof, odorless, and boilable. It resists perspiration, alcohol, urine and blood; stays smooth and pliable in hot and cold temperatures; will not crack or peel. Can be sterilized.

No. 806 Two-ply 36" width . . . .016 thickness . . . 25 yd. rolls . . . white—maroon—white/flesh, flesh/blue.

DOUBLE TEXTURE FLANNELETTE

Waterproofed sheeting, soft and absorbent, napped on both outer surfaces. Has inner layers of natural rubber. Used in baby's crib or adult hospital bed, directly over mattress. No other pad or sheeting necessary.

No. 105 36" width. White only. 12 or 25 yd. rolls.

RUBBERIZED *heavy weight* COATED SHEETING

Guaranteed to conform to Federal Specification ZZ-S-311a and all the requirements of CSTS-3551a as issued by the National Bureau of Standards. A calendered and vulcanized sheeting for general hospital use. Resists blood, alcohol, urine, perspiration, glycerine, medications. Can be sterilized many times.

No. 805 Double Coated 36", 45", 54" widths . . . .016 thickness . . . 25 yd. rolls . . . white maroon.

Durable *Vinylite* SHEETING

will not crack or become tacky

A light-weight sheeting for nursery, non-allergic covering and many other uses as a substitute for fabrics. This exclusive Plymouth Perfect sheeting is long-wearing and highly resistant to moisture absorption. Saves laundering. Light but durable — it won't crack or stick — wet or dry.

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SINCE 1896 Most widely bought, widest variety, of all waterproofed products

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POSITIONS OPEN

WOODWARD—*Continued*

ment. (c) 100-bed general hospital, no training school; hospital 2 years old; quaint Pennsylvania town; $4000. (d) 125-bed general hospital, church affiliated; degree not necessary; must have experience; southwest. (e) Small California hospital, no school; degree not needed; $4400; coastal town, 20,000. (f) New California hospital, all modern; 225 beds; no school; $6000. (g) Supervisor nursing service and school of nursing; must have experience in school supervision; postgraduate work preferred; $5000, plus full maintenance; one month vacation.

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

SURGERY NURSE—Also assist in deliveries, which are few; 50-bed approved hospital, copper mining area; excellent working conditions; $390 plus maintenance.

GENERAL DUTY—Fairly recent graduate for 50-bed hospital, small western town, elevation 6000 feet; $350 plus maintenance.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

DIRECTORS OF NURSES—(a) Middle west; 115-bed hospital; degree not required; $5000 plus apartment. (b) East; 225-bed hospital, fully approved; require at least 5 years experience as an instructor or supervisor; $6000 minimum. (c) Middle west; 200-bed hospital within easy commuting distance of Chicago; prefer Master's Degree; $6500. (d) South; 300-bed hospital located in large southern city; complete charge of nursing education and nursing service with the assistance of two associate directors.

DIETITIANS—(a) Chief; east; 180-bed hospital in city of 100,000; $5400, plus complete maintenance. (b) Assistant; east; tuberculosis sanitarium; new kitchen with all modern facilities; $4800 plus complete maintenance. (c) Therapeutic; middle west; 250-bed hospital; excellent opportunity for advancement if qualified. (d) Chief; Pacific Northwest; 125-bed hospital in city of 25,000; complete charge of dietary department; $5000.

PHYSICAL THERAPISTS—(a) Chief; middle west; 300-bed hospital, fully approved; $5000. (b) Director, physical therapy school; teaching hospital affiliated with well known university; have new cerebral palsy center and poliomyelitis clinic in department; $5000. (c) South; large hospital in large southern city;

SHAY—*Continued*

unusual educational and cultural facilities; 5 in department; $375 to start. (d) Middle west; 250-bed hospital, fully approved; $400 minimum to start.

PHARMACISTS—(a) West; 90-bed hospital; only one in department; to $5000. (b) Middle west; 325-bed hospital; 4 in department; to $4500. (c) Northwest; large hospital, 6 in department; to $4800. (d) South; 300-bed hospital in city of 50,000; $5000, minimum. (e) East; large hospital in city of 40,000; to $5100.

EXECUTIVE HOUSEKEEPERS—(a) East; 400-bed university hospital; 70 employees; 6 assistant housekeepers; $4500. (b) Southwest; 350-bed, new modern tuberculosis hospital; organize and operate housekeeping department; $3600 minimum plus complete maintenance to start. (c) South; 200-bed hospital, new; close to several large cities; $4200 minimum to start. (d) Middle west; 200-bed hospital; excellent staff; within easy commuting distance of Chicago; $3600 plus complete maintenance to start.

SATHER PLACEMENT SERVICE
138 North Twelfth Street
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DIETITIAN—With Master's Degree, teaching experience, ability to meet educators and free to travel; salary open.

NUTRITIONIST—Mature; Master's Degree from midwestern school; $4800 to $6000 plus travel expenses.

(Continued on page 240)



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POSITIONS OPEN

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) 125-bed hospital, south. (b) 100-bed new hospital under construction, south central state. (c) 85-bed hospital, Illinois. (d) 100-bed specialized hospital, east; building program; $10,000. (e) 50-bed hospital, Texas. (f) 35-bed hospital, Pennsylvania; $6000.

ASSISTANT ADMINISTRATORS—(a) 300-bed hospital, New England. (b) 250-bed church hospital; west. (c) Purchasing agent; 300-bed Ohio hospital. (d) Office manager; Pennsylvania; $325.

ADMINISTRATIVE DIETITIANS—(a) 275-bed Ohio hospital, $400. (b) Therapeutic; teaching dietitians; $325; excellent connections.

DIRECTORS OF NURSING—(a) 325-bed hospital, midwestern university city; $6000. (b) 250-bed hospital, south. (c) 250-bed hospital, New Jersey.

DIRECTORS, NURSING SERVICE—(a) 275-bed hospital, Ohio. (b) 200-bed hospital, east. (c) 125-bed hospital, New York state; $500.

CHIEF PHARMACIST—New York state; $450.

INTERSTATE—*Continued*

EXECUTIVE HOUSEKEEPERS—(a) 125-bed new chronic hospital, midwest. (b) 225-bed hospital, Massachusetts. (c) 300-bed New York hospital. (d) 175-bed hospital, Indiana. (e) 225-bed hospital, west coast. (f) Assistants; east.

TECHNICIANS—(a) Laboratory; to $375. (b) X-ray, $360.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
311 Land Title Building
Philadelphia 10, Pennsylvania

DIETITIANS—(a) Head; 450-bed hospital, east; top salary. (b) Assistant; 100-bed hospital; ADA not essential.

DIRECTOR OF NURSES—350-bed general hospital; graduate staff; $6000 plus partial maintenance.

EXECUTIVE HOUSEKEEPER—Large hospital, New England; salary open.

MEDICAL RECORD LIBRARIAN—Head; large hospital; $3600 plus maintenance.

PHYSICIANS—(a) January 1, 1954; one Pathologist, one Radiologist; certified or eligible, to head departments; 240-bed approved general hospital; good financial arrangements. (b) For clinical research; not a laboratory position; minimum starting salary $10,000.

(Continued on page 242)

MEDICAL PERSONNEL EXCHANGE
—Continued

TECHNICAL LIBRARIAN—For research and development department; large drug company; $5000.

No charge for registration

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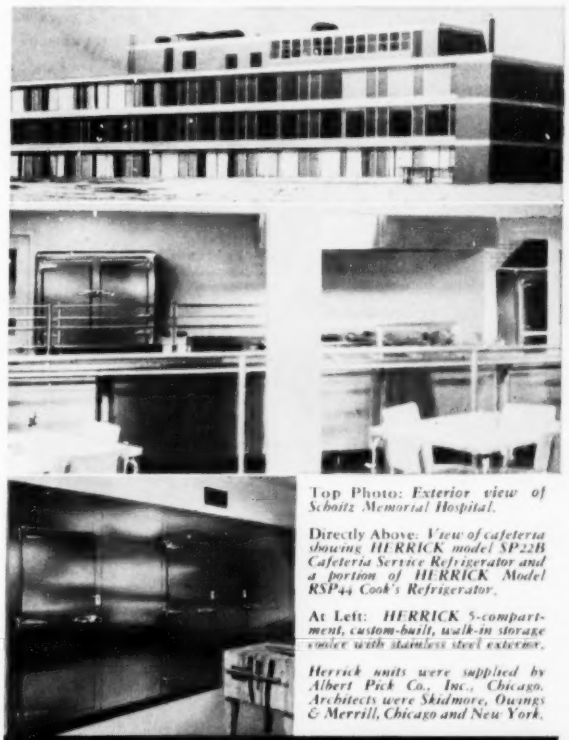
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Waterloo, Iowa



Top Photo: *Exterior view of Schoitz Memorial Hospital.*

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(Continued on page 244)

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2 oz. butter • 2 oz. flour • 2 tsp. curry • 1 onion chopped • ½ clove garlic • ½ apple grated • 1 tbsp. and 1 tsp. MAGGI'S GRANULATED BOUILLON dissolved in 1 pt. 6 oz. boiling water • ¼ c. moist cocoanut.

Saute onion and garlic in butter for 5 min. Mix flour and curry, add to butter mixture. Gradually add broth stirring until smooth. Lastly add moist cocoanut, 1 pint.

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Even the Rustproof Zippers are Electronically Welded — no sewing or thread to tear.



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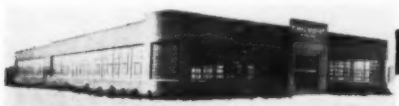
ADDED PATIENT COMFORT! Wrinkle-free, odorless . . . no rustling sound when patient shifts position.

*None GENUINE without this Registered Trade Mark.

Tremendously expanded production facilities enable us to pass on huge savings of 50%, as follows:

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Terms: net 30 days F.O.B. Englewood, N.J. Prices for other sizes upon request.



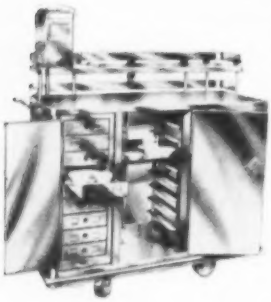
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Nothing — but *nothing!* —beats a good cup of coffee to make one's spirits soar. But it's *got* to be *hot* to be good! For more often than not, a patient judges his hospital by the flavor and savor of its food — and particularly by that essence of excellence, his coffee.

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NO. 1082



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Helical spring seat base. Metal cushion glides. Overall width—23". Overall depth—36". Overall height—38". Seat: Width—22"; depth—20"; height—18". Back: Width—23"; height—26". Available in all finishes. Shipping weight—40 lbs.

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The most efficient Double Mopping Outfit made with the added features of silent operation. Two Silent Oval Buckets — one for cleaning solution and one for rinse water and the "Can't Splash" Squeezer combined with a sturdy rubber protected steel truck that moves quietly and easily.

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It's RIGHT . . if it's

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A COMPLETE LINE OF FLOOR CLEANING EQUIPMENT



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Compare WITT CAN and PAIL features with others on these points . . .

STRAIGHT SIDES— assure extra resistance to rough handling.

DEEP ROLLING CORRUGATIONS— run full length of Can adding further rigidity.

HEAVY GAUGE STEEL— provides battleship ruggedness.

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WITT CANS and PAILS are guaranteed to outlast 3 to 5 ordinary CANS. That's your assurance of the highest standards of workmanship. WITT CANS and PAILS are designed to last longer . . . constructed to survive the most severe weather, wear, even deliberate abuse. It's no wonder that there are many WITT CANS and PAILS still in excellent condition after five, ten, yes even fifteen and more years of service.

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"Here is what we looked for...here is what we found...here is the answer to why we bought HOFFMAN Institutional Laundry Equipment."









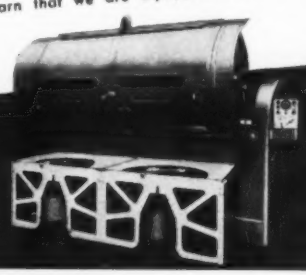
"First and most important was complete assurance of clean and sterilized linen at all times, processed with just the right amount of bleach, softener, soap and starch. Hoffman washers with their accurate controls and superior washing action gave that assurance.

Of almost equal importance were the noise and vibration factors. Site considerations made it mandatory that our laundry be situated in the basement of the building where such considerations might well affect the patients' rest and quiet. The silent chain drive of Hoffman flatwork ironer and the advanced engineering of the extractor offered the ideal solution of these nuisances.

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Twenty-four hours a day, three hundred and sixty-five days a year, the hospital must minister to the needs of its sick and injured. Dependability is the keyword! The experience of these institutions which we visited, with properly installed equipment and maintenance-free operation over long periods of time, and the comforting knowledge of parts and service at a moment's notice (as demonstrated by Hoffman's record throughout World War II) qualified Hoffman as absolutely dependable.

An added bonus not looked for in our original evaluation has been the favorable reaction of applicants for laundry positions when they learn that we are equipped 100% with Hoffman machinery."



*An actual letter in our files. Name on request.

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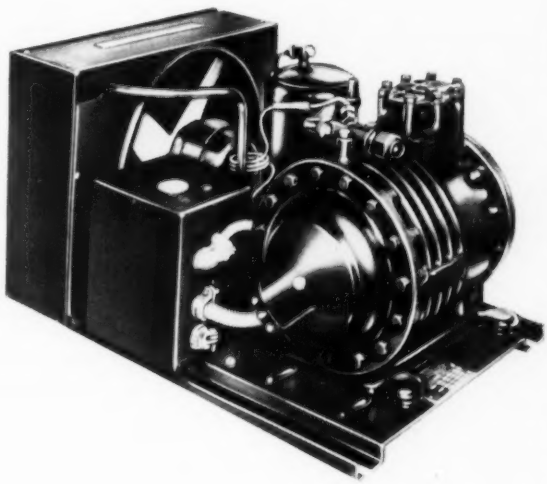
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Saves and saves in operation and maintenance over conventional compressors. Eliminates parts which cause most service calls.

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Takes less floor space than conventional compressors of comparable capacity. Lighter weight combined with resilient mountings allow greater flexibility in installation.

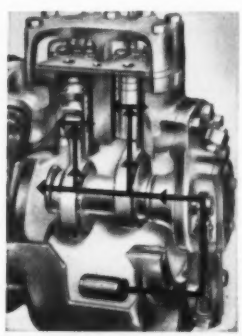


Extra Quality
Built from the inside out to most rigid precision standards and from highest quality materials.

Extra Efficiency
Years ahead design gives high output and low operating cost.

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Direct-drive, refrigerant-cooled motor, special bearings, pressure lubrication, guarantee day-in, day-out dependability.

Designed to stop trouble before it starts!



Full pressure lubrication means long life

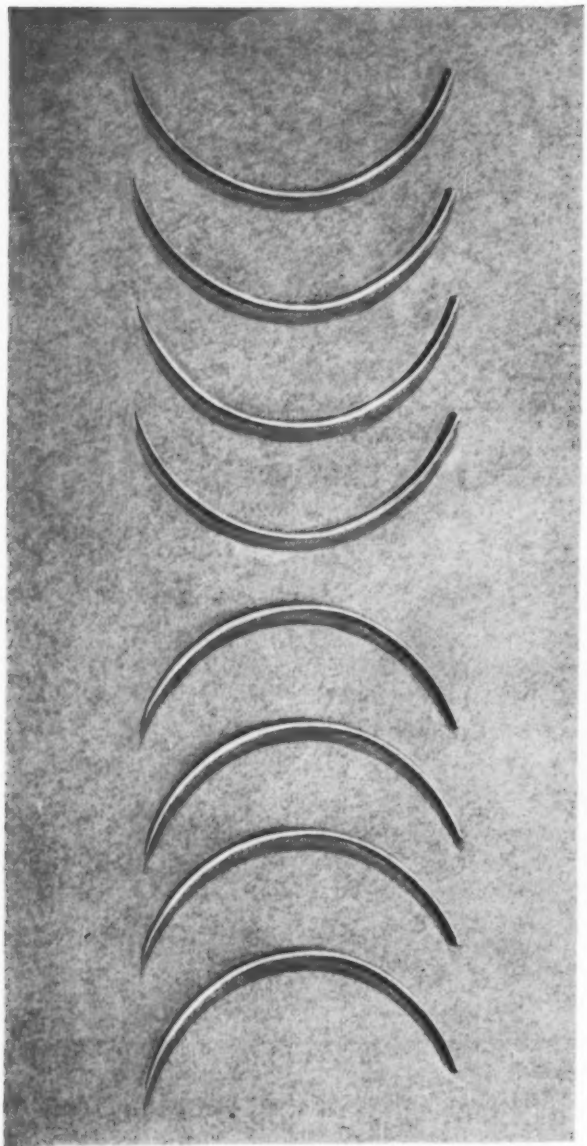
Continuous lubrication under pressure to all moving parts furnished by special oil pump. The end result is reduced friction and wear. This is another typical example of the extra quality features that mean long, trouble-free operation.

Here's the sensational new Frigidaire Compressor that's built to keep trouble away . . . built to banish the causes of 70% of all compressor service calls. Direct drive eliminates fly-wheels, motors, pulleys, compressor belts, and shaft seals. It's sealed against moisture, dirt, dust, and air; yet *all* parts are fully accessible for inspection and maintenance.

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Put them on chairs and furniture
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Angelica places great emphasis on the surgeon's comfort. (1) roomy raglan sleeves allow the surgeon freedom of movement, (2) tunnel belt provides snug fit.

because . . .

Angelica realizes the importance of sterility in operating room apparel: (3) the ample overlap of back panels, (4) the 54-inch finished length for full coverage and (5) the perspiration absorbent double stockinette cuff.

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because . . .

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Day-Brite Bed Lamps provide comfortable illumination in patients' rooms.

The 219-bed Mercy Hospital in New Orleans, Louisiana, joins the growing number of modern Day-Brite lighted hospitals.

From patients' rooms to service areas, Mercy Hospital's lighting system helps promote efficiency, safety and a cheerful, comfortable atmosphere.

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Day-Brite can help you solve your hospital lighting problems as it has for many administrators. For more information, write Day-Brite Lighting, Inc., 5455 Bulwer Ave., St. Louis 7, Mo. In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ontario.

"DECIDEDLY BETTER"
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Lighting Fixtures

DAY-BRITE HOSPITAL LIGHTING FIXTURES

364

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What's New for Hospitals

OCTOBER 1953 Edited by BESSIE COVERT

To HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 280. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Oxygen Timer



A new device has been introduced for the automatic timing of the flow of oxygen to the patient. Known as the Oxy-Tymer, it is designed to simplify hospital billing procedures by keeping an accurate record of oxygen used, whether on time or liter rate basis. With the Oxy-Tymer there is no loss of revenue due to unrecorded or overlooked oxygen use. At the same time, it provides an accurate medical record, for the doctor, of oxygen used.

The Oxy-Tymer is ruggedly constructed to withstand normal hospital use without damage. It is quickly and easily installed on any flowmeter or oxygen therapy equipment and cannot interfere with the flow of oxygen to the patient. It can be used with or without a humidifier. The instrument is housed in a heavy gauge, gray enamel finished aluminum case. **Virber Company, Dept. MH, Box 2743, Dallas, Texas. (Key No. 198)**

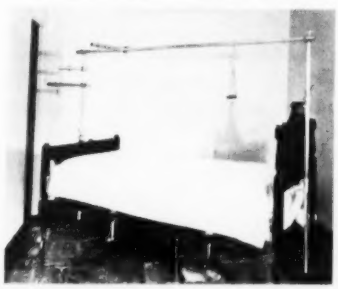
Surgical Gut

Surgical Gut has been added to the line of sutures now offered by Deknatel. The line now includes sterile silk in "Readi-Cut" lengths as well as non-traumatic needle combinations of gut and silk. A new plant has been erected and special equipment employed to ensure high quality in tthe new surgical gut line, which has been subjected to thousands of tests and experiments. **J. A. Deknatel & Son, Inc., Dept. MH, Queens Village 29, Long Island, N.Y. (Key No. 199)**

Perforated Acoustical Material

A new perforation design is offered in Armstrong Full Random Cushiontone acoustical material. The new design has non-directional perforations, spaced at random over the face of the tile. It provides a change from the straight-line perforation design and offers greater freedom in creating interiors with a low-cost acoustical treatment. The new Full Random Cushiontone has narrow bevels with minimum border between the perforations and bevel. It has high light reflection and the factory painted surface is washable. It may be repainted with an oil base paint if desired. **Armstrong Cork Co., Dept. MH, Lancaster, Pa. (Key No. 200)**

Overhead Fracture Frame



The new Zimmer Six-Forty Octagon Overhead Fracture Frame is made in separate sections that clamp together and adjust easily to any type of bed. Made of strong aluminum alloy, the parts are light in weight and easily handled even by small nurses. Positive anchorage of cross arms without marring the tubing is provided through the octagon shape of the tubular sections. Clamps on cross arms are of heat treated high tensile aluminum alloy. Roller bearing pulleys fit at any point on the tubing without sliding the clamp over the end of the tube and are easily attached or detached. Rubber protected clamps slide up and down for correct positioning on the bed, regardless of size or type. Accessories and attachments for all fracture needs are avalable for use with the new frame. **Zimmer Manufacturing Co., Dept. MH, Warsaw, Ind. (Key No. 201)**

(Continued on page 254)

Dishwashing Detergent

The new type liquid detergent, Hil-Suds and the work-saving Maintaineer Dispensing Unit have been developed to facilitate dishwashing. Scum and rings are eliminated from the wash tank and soap, water and time are saved in the dishwashing operation. Hil-Suds is a powerful grease emulsifier detergent, already dissolved and instant acting, with a wetting property which leaves no residue and results in faster drying. The product is non-alkaline, non-poisonous and is effective in either hard or soft water, hot or cold.

The Maintaineer dispenser effects savings on soap. It is a finely machined meter that automatically feeds a minimum of Hil-Suds for the desired job, without waste. The dispensing unit is easily connected, without special tools or plumbing and operates on any faucet. **Hillyard Chemical Co., Dept. MH, St. Joseph, Mo. (Key No. 202)**

Conductive Floor Tester

All attachments for testing flooring, furniture, parts and supplies used in hazardous locations are included in the new conductive floor and equipment tester. Made in accordance with N.F.P.A. Bulletin No. 56, 1952, the tester is simple to operate and effective in results. A selector switch on the tester has three settings: one for floors, rubber tubing and parts, one for rubber sheeting, operating table, pad and pillow covers, and one for casters, tires and leg tips. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 203)**



What's New . . .

Mobile Commode



Designed to help induce bowel movement and micturation without discomfort or danger to the patient, the new Greenline Mobile Commode has an adjustable foot rest, leg rest and an adjustable seat for greater comfort and relaxation. The front of the seat can be raised by a crank to provide the comfort of a contour chair. A stainless steel bedpan fits into a flanged opening flush with the seat.

The commode is easily rolled into position. The rubber-tired, ball bearing wheels have convenient, foot-operated locks that prevent any movement when in use. The arm rests can be lowered while the patient is being seated, then locked in place for convenience and security. The Mobile Commode was developed because of many requests from clinicians for equipment to serve this purpose. It is made of stainless steel with all welds polished to provide smooth, seamless construction for easy cleaning. **Robert M. Green & Sons, Inc., Dept. MH, Nesquehoning, Pa. (Key No. 204)**

Fixture Hanger

A new type of lighting fixture hanger has been introduced to speed up leveling and aligning of lights. The Stem-Winder incorporates an ingenious Stem-Winder leveling device and a 25 degree swivel. Fixtures can be easily leveled after installation without the use of tools and without cutting or re-threading stems. The unit is complete with hickey and crossbar for outlet box ears or stud. **The Miller Company, Dept. MH, 99 Center St., Meriden, Conn. (Key No. 205)**

Immersion Hot Water Boiler

A heating element and water storage tank are combined in one unit in the new immersion 2-pass hot water boiler. Savings in floor space as well as in fuel are the result. The new boiler is available in capacities from 250 to 5000 GPH, with either gas or oil firing or combination. **Mund Boilers, Inc., 1600 N. Indiana St., Los Angeles 63, Calif. (Key No. 206)**

Adjustable Coat Rack

Double the capacity for coats and hats is possible with slight increase in floor space with the new collapsible wardrobe racks developed by Vogel-Peterson. The three foot rack has a capacity of 48 coats and hats and the four foot unit holds 64 coats and hats on slightly more than four square feet of floor space.

Another feature of the new racks is the positioning of hanger bars for long robes, adults or children's clothes. The units can be dismantled easily for storage or transportation and quickly set up again with tools or fasteners. They are equipped with casters for easy mobility. **Vogel-Peterson Co., Dept. MH, 1127 W. 37th St., Chicago 9. (Key No. 207)**

Commodore Plaid Blankets

A bright, cheerful accent for private rooms, solariums and nurses' homes and other residence quarters can be added with the new Horner Commodore Plaid Blankets. These large 72 by 90 inch



blankets of fine quality all wool are available in a wide range of plaids, including Empire Green, Camellia Rose, Fiesta Yellow, Vista Blue, Dress Stewart and Frazer Red. Ends are satin bound for durability and added attractiveness. **Horner Woolen Mills Co., Dept. MH, Eaton Rapids, Mich. (Key No. 208)**

Binding Punch

An electric-powered punch has been added to the equipment offered to facilitate the binding of loose pages of records, catalogs, literature, reference and other material. The Model 116-EP is an electric power punch which can handle up to 20,000 sheets per hour. It supplements the smaller punches available in the line. The cost of the new machine for high-speed punching is relatively low and the design and construction have resulted in a machine of relatively light weight. It requires no special tools for set up, no special wiring and no special operator training. The unit saves floor space, is durably constructed and is streamlined in design. **General Binding Corp., Dept. MH, 812 W. Belmont Ave., Chicago 14. (Key No. 209)**

(Continued on page 258)

"Color-Coding" for Sponges

Kenwood Surgical Sponges are now being made available in an interesting new packaging development known as "Color-Coding." The new system provides a distinguishing individual color for case labels and bags for each different type of surgical sponge. Bright red is used for case labels and bag printing for all gauze sponges, green is used for cotton filled sponges and bright royal blue for x-ray opaque sponges. Time is saved in the selection of sponges from bulk stocks and the color-coding system eliminates confusion in selection and use. **Will Ross, Inc., Dept. MH, 4285 N. Port Washington Rd., Milwaukee 12, Wis. (Key No. 210)**

Kimble Toplight System

Consisting of panels of glass and aluminum which are factory fabricated, ready for installation in the roofs of buildings, the Kimble Toplite System is designed to provide natural overhead light. The glass units were developed in the Daylight Laboratory at the University of Michigan and have high light transmitting characteristics while eliminating glare and tempering solar heat. The scientific design of the units is such as to make them transmit a high percentage of the light from the low winter sun and from the north sky while reflecting much of the direct light from the high summer sun.

The hollow glass units, 10⅞ inches square by 3 inches thick, are set in insulated aluminum grids and are made weatherproof by the pouring of a specially prepared compound over the structural ribs. The unit provides insulation and therefore eliminates condensation under most weather conditions. The completed panels are made in four stock sizes and may be used singly or combined in groups. They



provide evenly diffused light and installation cost is low since the units are prefabricated in the factory. **Kimble Glass Co., Dept. MH, Ohio Bldg., Toledo 1, Ohio. (Key No. 211)**

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FOOD CONVEYOR SYSTEMS
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TRUSTWORTHY



No business . . . no institution . . . can prosper long without trustworthy employees, or trustworthy equipment. In the hospital this is particularly true. For here you deal with human life.

The fact that for over 70 years countless hospitals have continued to use Ivory Soap offers ample evidence that medical authorities have found Ivory trustworthy.

Ivory offers the hospital everything it demands of a soap for patient care. It is superbly pure . . . it lathers richly even in hard water . . . it cleanses the skin thoroughly and agreeably . . . it has no perfume which might offend.

Ivory is truly a valued "assistant" in countless hospitals. You will find it particularly well qualified to serve *your* institution.

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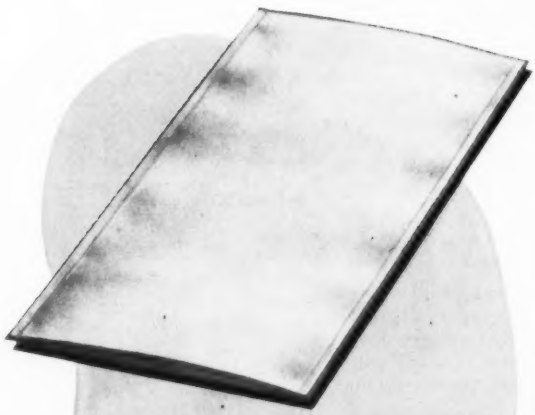
Pure, mild, rich lathering Ivory Soap is available for hospital use in the popular 3-ounce (packed weight) size as well as in four smaller sizes—wrapped or unwrapped.

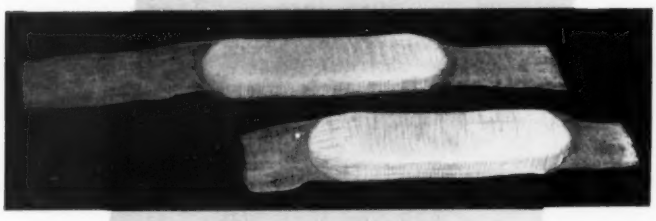
99 44/100% PURE . . . IT FLOATS

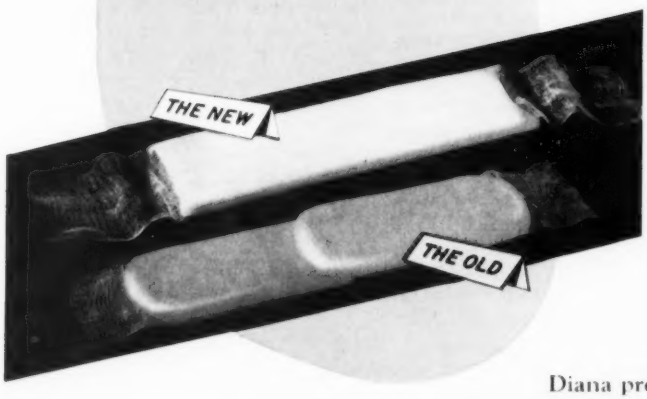
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1. Our THRIFTY underpad with its non-woven *textile* cover. This cover makes the pad as comfortable to lie on as the bed sheet itself. The textile is so strong too, that, unlike paper, it doesn't disintegrate when wet and stick to the patient.* Because of its low price and nursing time saved,* we call it THRIFTY.

2. Our popular highly endorsed Short & Long Tab Hospital Sanitary Napkins, with the added features of both deodorant and moisture-repellent shields.

3. Our extensively used new 12" O.B. MATERNITY Pad with long tabs. Soft pure cellulose filler, free of impurities and of highest absorbency. Over this filler is a velvety, fleecy cotton cover, and over this cotton cover is an outer wrap of surgical gauze especially treated for softness.

*Even a half minute per pad, required picking off paper which sticks, represents almost 2 hours saved per case in use.

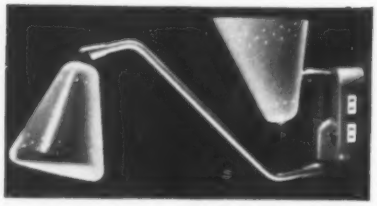
Diana products are not sold direct but through hospital supply houses who sell under their own label.

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What's New . . .

Hospitality Light



Five lighting needs can be handled successfully in one unit known as the Hospitality Light. It is plugged into a wall-mounted receptacle fitted to a master outlet. It can be quickly removed and replaced for easy maintenance.

The flexible unit provides a reading light on a double swivel arm, adjustable to any position the patient may desire. It also provides an indirect light for general illumination. Tilted downward, the indirect light provides an examination light when needed. A night light in the housing directs a fan-shaped beam behind the bed which does not interfere with the sleeping patient. One or two convenience outlets for electrical appliances are a part of this versatile fixture. **Kurt Versen Co., Dept. MH, Englewood, N.J. (Key No. 212)**

X-Ray Protective Apron

A patented design which eliminates the discomfort of weight on the wearer's shoulders has been used in the new Keleket X-Ray Protective Apron. The majority of the apron's weight is distributed over the hips instead of the shoulders by an ingenious strap arrangement. The apron is adjustable to the wearer's height and girth and can be fitted or removed in one easy overhead movement. It is ruggedly constructed with heavily reenforced, sewn strap and non-corrosive buckles. It weighs 10 pounds, has .5 mm. lead protection and is cloth covered on the side facing the wearer. **The Keleket X-Ray Corporation, Dept. MH, 208 W. Fourth St., Covington, Ky. (Key No. 213)**

Windall Sills

Window sills that never need refinishing, are weather-safe, easy to maintain and easy to install are available in the newly developed Windall Sills. They are unaffected by heat, cold, sun, rain and condensation and do not spot. The heavy-bonded Formica surface is unharmed by alcohol, fruit acids, boiling water and ordinary cleaning alkalies. They are cleaned by wiping with a damp cloth. Windall Sills are available in dark walnut, limed oak, marble, Gray Fernglo and Buff Fernglo finishes. **Woodall Industries, Inc., Cleveland Div., Dept. MH, 1890 Carter Rd., Cleveland 13, Ohio. (Key No. 214)**

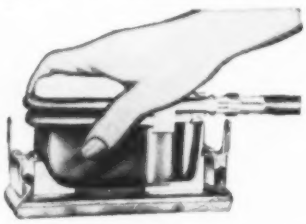
Boiler-Burner Unit

The new Titusville-Iron Fireman Boiler-Burner unit has been developed for high or low pressure heating, power and process steam. It is sold and serviced as a completely packaged unit and operates on oil, gas, or oil and gas combination. It is shipped completely assembled and ready for operation as soon as connections are made.

The boiler has ASME Code construction throughout and was designed with unusually large furnace volume to assure lower heat release, with proportionally longer service life. Two basic types are supplied in the boiler-burner unit; power units and heating boilers. They have been developed by **Titusville Iron Works Co., Titusville, Pa., and Iron Fireman Mfg. Co., Dept. MH, 3170 W. 106th St., Cleveland 11, Ohio. (Key No. 215)**

Air Sander

A small, light air sander is now available for woodworking and maintenance use. The Model J-R air-powered Detroit Easy Finisher has a small palm-size grip for maximum operator comfort



and an air switch type control. It is easy to use the abrasive holder for attaching several sheets of sand paper at one loading and it has the No-Surge automatic mist-type water spray for wet sanding. The machine offers fast cutting and operates with the same Strate-Line reciprocating action of heavier Detroit models. A unique slide action design for attaching the pads allows off-center adjustment of the pad, permitting sanding in grooves up to protruding trim and other hard-to-reach areas. It also permits instant attaching of desired types of sanding pads to fit the job. **Detroit Surfacing Machine Co., Dept. MH, 1333 E. Eight Mile Rd., Detroit 20, Mich. (Key No. 216)**

Floor Tile

Two new flooring materials introduced recently by Sloane-Delaware are Koroseal Tile Imperial and Cork Tile. Koroseal Tile Imperial is an all-vinyl tile with an unusually long wearing surface in its price range. It is a high quality flooring with grip-tight back and precision cut for quality floor tile installation in institutions. It has a new vinyl color formulation and is available in 12 colors in the 9 by 9 inch square floor tile size.

Sloane Cork Tile is manufactured by a modern, low-temperature process which eliminates the charred wood odor. Features of the new tile include long wear, great resilience, fine color uniformity and high resistance to stain. This light, sound-absorbent material is suitable for use on floors and walls and is available in natural coloring in $\frac{1}{8}$ and $\frac{3}{8}$ inch gauges in 9 by 9, 6 by 12 and 12 by 12 inch sizes. **Sloane-Delaware Floor Products, Dept. MH, Trenton, N.J. (Key No. 217)**

Economy X-Ray Illuminator

Improvements to the Halsey Economy Illuminator include a fully functional two-way clip. With the clips down, x-ray film rides easily into position under the ball rollers, and stays securely in place. When the clips are up, they become non-slip arms for wet-film viewing. Other features include the new Halsey grommeted cord, locked-reflector to eliminate electrical shorts, a channel to hold the viewing surface securely at the bottom, and mitered corners for a smoother front. **Halsey X-Ray Products, Inc., Dept. MH, 1425 37th St., Brooklyn 18, N.Y. (Key No. 218)**

Kent Floor Machines

Two new Kent Floor Machines have recently been introduced, the K-15 and the K-17. Both machines are ruggedly constructed for long, hard use and can be used for polishing, scrubbing, buffing and steel-wooling. They operate easily and quietly and have a minimum of moving parts. Handles are adjustable to any height and they have automatic safety switch which operates with either or both hands, and fully enclosed dust-proof, waterproof motor, with gears running in a continuous bath of grease.

Both machines feature the Kent "Floating Power" for smooth power, and "Balanced Power" with motor off center to counterbalance handle and counteract torque. All weight is on the brush, facilitating cleaning, and the machine



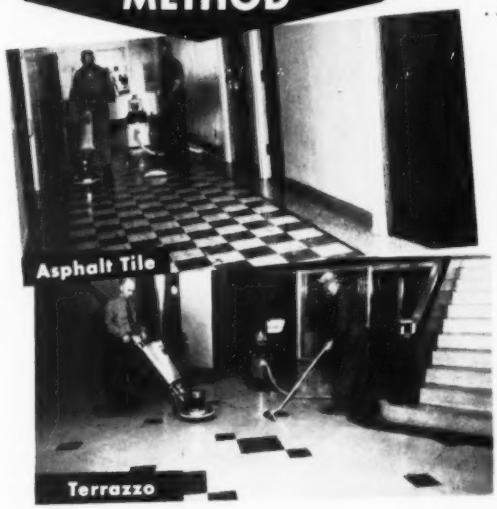
can be equipped with a solution tank for scrubbing large floor areas. **The Kent Company Inc., Dept. MH, Rome, N.Y. (Key No. 219)**

(Continued on page 262)

THE MULTI-CLEAN METHOD

IT'S DIFFERENT! ... NOW LASTING BEAUTY ... LESS UPKEEP ... FOR ALL YOUR FLOORS

... THIS NEW IDEA IN FLOOR MAINTENANCE IS BEING ACCEPTED BY MORE AND MORE ENTHUSIASTIC USERS EVERY DAY!

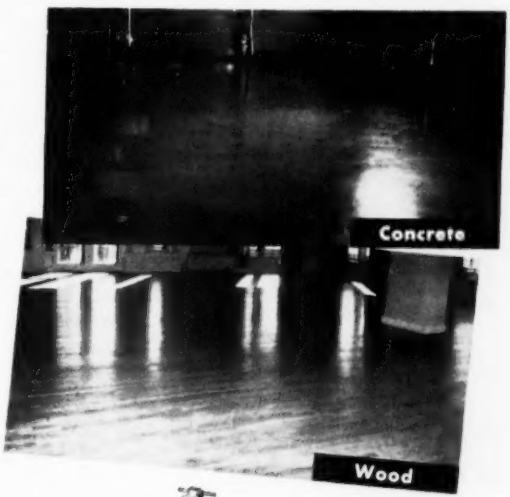


For ASPHALT TILE FLOORS . . . From now on you won't have to wax those asphalt tile floors to keep them good-looking and well protected. Multi-Clean Asphalt Tile Preserver is a complete finish in itself . . . it provides a long-lasting, glossy finish, and is U/L approved as anti-slip. It ensures continuing beauty and protection for all your asphalt tile. If you prefer to continue waxing your floors, you'll find Asphalt Tile Preserver an excellent base for wax. It makes the wax look nicer and saves you money because less wax is needed. With the *Multi-Clean Method*, ordinary dry sweeping or vacuuming and weekly damp mopping keep asphalt tile clean . . . buffing with a Multi-Clean Floor Machine equipped with a polishing brush or steel wool disc will restore the original lustre.

For TERRAZZO FLOORS . . . Now your terrazzo floors can have a brilliant lustre yet be extra-safe to walk upon when they are protected by Multi-Clean Terrazzo Sealer . . . the terrazzo treatment approved anti-slip by U/L. It penetrates and seals the surface against moisture, dirt and grease. Water-clear in color, it will not yellow with age. It gives your terrazzo a beautiful satiny finish. Floors are ready for traffic within 30 minutes after application. This *Multi-Clean Method* requires only dry sweeping and periodic wet mopping for maintenance.

For CONCRETE FLOORS . . . Two types of concrete floor treatments, each formulated to meet your own special floor condition are available to you with the *Multi-Clean Method* of floor care. Both Multi-Clean Neo-Dry Concrete Sealer (rubber-base) and Multi-Clean Concrete Preserver (bakelite-base) provide tough finishes that resist scuffing and wearing, that are not affected by water, grease, oils, or alkalies, and will not peel, chip, or fade with age. They'll give you an excellent base for wax, cut sweeping time and reduce the need for damp mopping.

For WOOD FLOORS . . . The speed and ease with which your wood floors are kept in first-class condition with the *Multi-Clean Method* will reduce your maintenance costs. Even under heaviest foot traffic, your floors will retain their safe, glossy finish for longer periods between treatments. Ordinary dry sweeping will keep them clean, and periodic polishing with a Multi-Clean Floor Machine will remove the usual surface dirt and scuff marks, restoring brightness and lustre.



What is the MULTI-CLEAN METHOD?

The *MULTI-CLEAN METHOD* is a carefully planned and thoroughly tested procedure, developed by men who know floors and floor maintenance, for the most efficient and economical maintenance of floors. The Method specifies the use of proper materials and floor maintenance equipment with the correct applications for all types of floors and floor conditions.



Tested finishes for all types of floors.



All-purpose floor machine mechanizes maintenance.



High performance wet-dry vac is fast and efficient



FREE! GET THIS NEW FLOOR MAINTENANCE MANUAL!

Tells how to care for asphalt tile, concrete, wood, terrazzo, rubber tile, linoleum — easier floor maintenance at lower cost!

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2277 Ford Parkway, Dept. MH-10, St. Paul 1, Minn.
Please send me your FREE Maintenance Manual for all types of floors, also information on equipment checked.

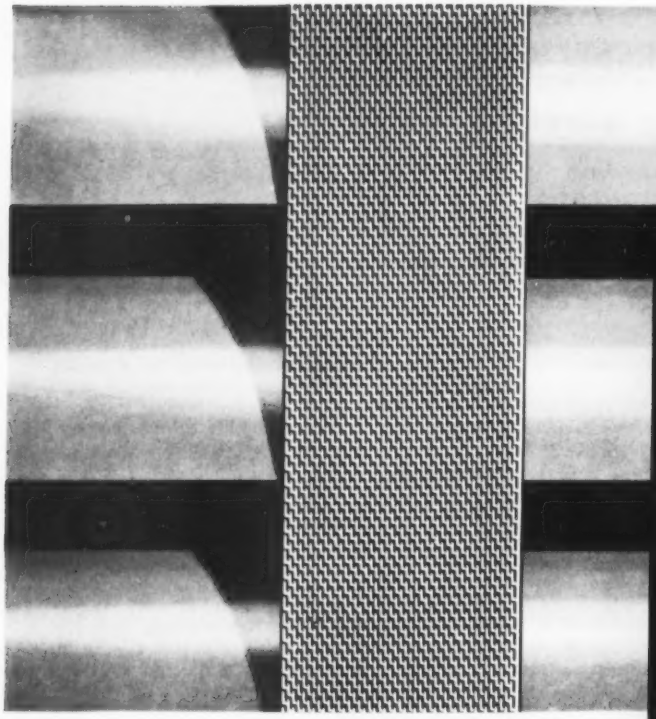
☐ 9-Job Floor Machine ☐ Wet-Dry Vacuum ☐ All-Purpose Scrubber

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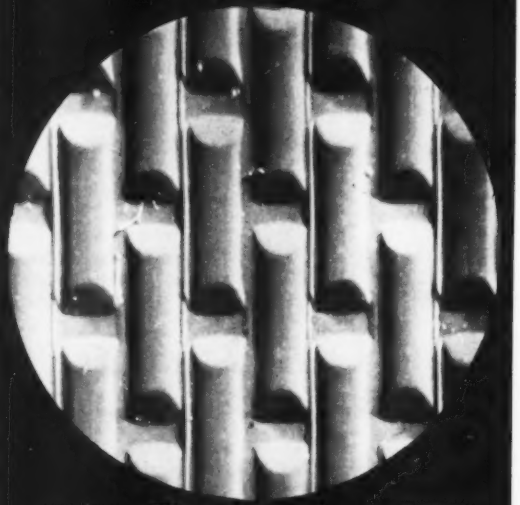
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Surface of cotton tape,
enlarged 44 times



Surface of Flexalum plastic tape,
enlarged 44 times

a glance tells you why: only all *Flexalum*® blinds are **completely sanitary**

Non-porous plastic tapes—wipe completely clean with a damp cloth. Will not fade, mildew, fray, shrink or stretch.

Slim nylon cords—stay clean, won't fray or fade.
Soft plastic tassels—stay clean, won't break or rattle.
Sleek enameled aluminum slats—shed dust. Spring-tempered, they always keep their shape. Mar-proof finished, they won't rust, chip, crack or peel.

Also—**Non-slip tilt control**—Cords always in reach. Permanently locked to friction-free mechanism.

No loose fibres, no porous openings to absorb dirt. Tests* prove bacteria do not penetrate Flexalum surface, are wiped off far more readily and completely. Flexalum plastic tape is sanitary to start with, easy to keep that way.

*Gar-Baker Laboratory, New York City

Specify all-FLEXALUM blinds for sanitation, durability, and ease of maintenance. Write for local all-Flexalum source and free file of venetian blind information.

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Go down the line with TILE-TEX for all your Floor and Wall needs!

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in over 80 lovely colors...and a wide range of sizes. The new flexible Mura-Tex Wall Tile is the perfect answer for wainscoting large areas.

Flexachrome* Vinyl Plastic-Asbestos Floor Tile



The aristocrat of resilient flooring . . . "dresses up" an area *beautifully* . . . and how it *wears!* 28 sharp, brilliant colors and 5 sizes give you almost limitless versatility for design and pattern. It's *greaseproof*, too . . . so you can use it almost *anywhere*. Does not require waxing.

Vitachrome† Greaseproof Resilient Floor Tile



A light-colored *beauty* of a tile with exceptionally high *light reflectivity*. With its high resistance to food greases and oils, Vitachrome is excellent for use in kitchens, restaurants, cafeterias, pantries. Easy to install and maintain, it requires only the usual daily sweeping, periodic washing and occasional waxing.

Tuff-Tex* Greaseproof Industrial Floor Tile



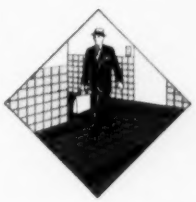
TUFF-TEX lives up to its name! A truly heavy-duty flooring material. Use this tile in machine areas, service stations, kitchens, cafeterias . . . anywhere grease abuse is a problem. It's so rugged that it will stand up under traffic of material handling trucks, yet in colors that brighten drab interiors.

Tile-Tex* Asphalt Floor Tile



The standard of quality within the industry! For general use, this tile gives you an exceptionally durable flooring material that combines low first cost . . . easy, economical maintenance. It offers you distinctive design possibilities, due to a wide range of colors and sizes.

Mura-Tex* Plastic-Asbestos Wall Tile



A new flexible wall covering that is ideally suited for commercial, industrial, or residential wainscoting and walls.

Mura-Tex Wall Tiles enable you to carry out your decorator scheme with a beautiful, *easy-to-clean* greaseproof material that resists acids and alkalies.

See Your Tile-Tex Contractor... listed in your classified telephone directory under the Tile-Tex trademark for complete information or write:

THE TILE-TEX DIVISION, *The Flintkote Company, 1234 McKinley Street, Chicago Heights, Illinois*

Tile-Tex—Pioneer Division, *The Flintkote Company, P. O. Box 2218 Terminal Annex, Los Angeles 54, California.*

The Flintkote Company of Canada, Ltd., *30th Street, Long Branch, Toronto, Canada*

†TRADEMARK OF THE FLINTKOTE COMPANY
*REG. U. S. PAT. OFF.

TILE-TEX... Complete Flooring Service

What's New . . .

Silent Mop Wringer



The new White Silent Mop Wringer employes the "Rol Ovl" mopping bucket which is oval in shape, heavily built, and insulated throughout against noise in operation. It is equipped with a unique friction bail which is covered with a rubber grip at point of contact with bucket rim to protect against noise. A long wearing rubber guard protects the bucket base rim. The wringer is firmly attached, has rubber rollers, and is silent in operation. The whole unit has been designed for use in hospitals and other institutions where quietness is essential. **White Mop Wringer Co., Dept. MH, Fultonville, N. Y. (Key No. 220)**

Sanitary Disposable Slippers

Sani-Scuffs, foot-molded of attractively colored paper-mache, are offered at low cost per unit. These sanitary disposable slippers can be used by hospital patients when going to the bathroom or to laboratory, x-ray or other departments. They are comfortable and can be easily slipped on or off. Their low cost permits discarding after use and when worn, the patient is protected against infection or discomfort. The soles are thick, semi-flexible and non-skid and the inside is corrugated to grip the foot. Sani-Scuffs take up little room and can be kept readily available at the bed side. **Sani-Scuff Company, Dept. MH, 405 Lexington Ave., New York 17. (Key No. 221)**

Contact Deodorant

The new non-toxic contact deodorant, "10-39," is practically odorless and not a masking agent. It employs the odor counteraction principle and has been specifically designed to counteract odors which cling to walls, flooring, tile, metal surfaces and rubber sheeting. It is described also as an effective deodorant rinse for rubber gloves, bed pans, urinals, drainage pans, diaper and garbage cans.

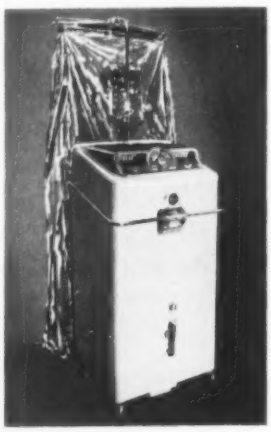
A highly concentrated agent, "10-39" is diluted in water for use. It is non-inflammable, contains no formaldehyde and will not bleach or stain, according to the manufacturer. **Airkem, Inc., Dept. MH, 241 E. 4th St., New York 17. (Key No. 222)**

Visible Filing Equipment

Punched and tabulated cards can be filed in the new VIStem visible filing equipment. All tabulating cards are visibly filed, facilitating quick location. The files are made in small, portable models, mobile posting units, large desk units and counter height units. All units operate on the visible vertical principle. Compactness, large capacity and instant visibility are features of the new equipment. **VISIrecord, Inc., Dept. MH, Copiague, L. I., N. Y. (Key No. 223)**

Melco 280 Humi-Tent

Developed in conjunction with Moist Air Therapy studies by Dr. Francis F. Schwentker, Professor of Pediatrics and Pediatrician-in-Chief at Johns Hopkins Hospital, the Melco 280 Humi-Tent permits the administration of "super-moist air" plus free moisture in suspension, and control of temperature. A pilot



model of the new unit was used successfully in a recent epidemic of poliomyelitis in Texas.

The tent is designed for the treatment, in an atmosphere saturated with moisture to the point of fog, of patients with pulmonary, inflammatory conditions such as acute bronchiolitis and bronchopneumonia. The fog produced is of sufficiently small particles that droplets are inhaled in the bronchial tree. This is accomplished without precipitation, ensuring a relatively dry patient, and with control of temperature within comfortable levels.

The heavy-duty humidifier motor on this new model is an impregnated bronze casting for lifetime service. The heating system was specifically designed for this application. The Visi-Glo Instrument Panel lessens danger of improper operation of the unit and the narrow margin thermostatic cooling, heating and temperature controls simplify setting and maintaining accurate temperature. **Melchior, Armstrong, Dessau Co., Dept. MH, Ridgefield, N.J. (Key No. 224)**

(Continued on page 266)

Flooring and Surface Coating

New materials, known as SURCO, have been developed for use as floors, drives, sidewalks, highways, to waterproof, to stucco and plaster walls, and as a concrete where vibration is a problem. The result of more than three years of research and field testing, the products are tough, flexible and water-retardent flooring and surface coating materials which bind to masonry, concrete, plaster, wood, glass and metal. They are similar to regular concretes or plasters but special latex-water emulsion binders instead of water alone are used as the combining agent. Two general types of latex have been developed to meet the varied demands of construction and maintenance. Both are tough and have high adhesive qualities but one has amplified waterproofing qualities and the other accentuated wear resistance.

SURCO can be applied directly and without special preparation to metal decks, stairs, pipe joints and coverings. By the use of colors and marble chips, an ornamental flooring is obtained at relatively low cost. It can be used as a roofing, flashing, putty or caulking compound or as a non-shrinking mortar to set tile, marble, brick or limestone. It can be colored in an unlimited range or can be painted. **Surface Coatings, Inc., Dept. MH, 110 Pear St., Atlanta, Ga. (Key No. 225)**

Bind-X Label Holder

Bind-X Label Holder is a transparent plastic window, 1 or ½ inch wide, with self-adhesive. It is designed for use on shelves; map, plan and blueprint compartments; storage compartments or bins, and the backs of loose-leaf books, binders and other material to be specially marked. The material is made in 6 inch lengths and may be cut to any dimension desired. The window is backed by a strong reenforcement coated with a pressure-sensitive latex adhesive so that it adheres firmly to wood, leather, glass, metal, stone, paper, fiber and plastics. A printed, typewritten or hand-lettered label is inserted into the window. Labels are easily removed for changing and Bind-X is available in



eight different colors as a further quick means of identification. **Cel-U-Dex Corp., Dept. MH, 1 Main St., Brooklyn 1, N. Y. (Key No. 226)**



Why cover your walls with redecorating dollars?

Use

VARLAR

Stainproof Wall Covering

AND SAVE THOUSANDS OF DOLLARS YEARLY!



Soap and water washes **VARLAR** fresh and clean without injury to surface or colors...up to 25,000 times

Put the skids under the high cost of cleanliness. Decorate with Varlar and your redecorating materials for years to come cost as little as the water from your faucet and a box of soap!

That's right! Stains that put an early end to other wall finishes, wash off Varlar with just soap and plain water . . . actually up to 25,000 times. Grease, grime, smoke, food stains, crayon, lipstick, ink, Mercurochrome—and many more—vanish to leave your walls always fresh, always new looking, always inviting. In addition, Varlar offers amazing resistance to fire, vermin and abrasion.

There's no doubt about it! Varlar, now available in more than 235 attractive styles, is the truly modern, functional wall covering. See for yourself why Varlar's popularity continues to grow . . . send for free testing samples today!

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a product of United Wallpaper Inc.

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Please send FREE TESTING SAMPLE and full information on VARLAR Stainproof Wall Covering. I am particularly interested in VARLAR for:

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Upjohn

absorbable hemostat:

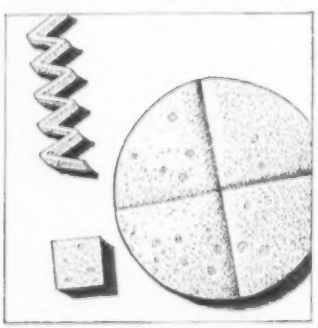
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Available in a large variety of sizes and forms, including:

Surgical sponges
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Dental packs
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Tumor diagnosis kit

The Upjohn Company, Kalamazoo, Michigan



264 The MODERN HOSPITAL

Now... a thicker, softer KOTEX* maternity pad



New improved 656 KOTEX 12-inch pad is fluffier and more efficient

The picture tells the story. New 656 KOTEX gives you more pad for your money. Here is a fluffier, softer *improved* version of the maternity pad more hospitals use than any other.

New 656 KOTEX is thicker, *fluffier*—made by a new process which lays Cellucotton* fibers as gently as snowflakes into a fuller fluff filler.

Other new features: Rounder, softer edges for greater patient comfort. Ends, as well as sides, completely enclosed (a KOTEX exclusive) by super-soft 4-ply crepe wadding. New lengthwise direction of crepe fibers distributes stain over greater pad area, keeps it away from sides. And no increase in price!

To complete the technique, use the new KOTEX hospital belt. Forget old-fashioned T-binders. New belt slips around waist and snaps on—*no pins!*

Save dressings costs and hours of nurse time. See your Curity representative for details today!

IMPROVED

No. 656 KOTEX*

AND HOSPITAL BELT

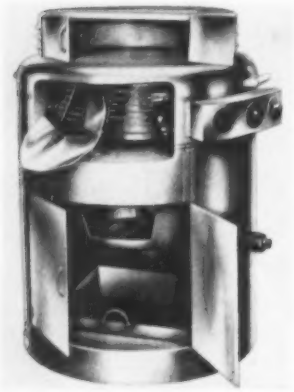
BAUER & BLACK

Division of The Kendall Company
309 W. Jackson Blvd., Chicago 6, Ill.

*T. M. Reg. U. S. Pat. Off.

What's New . . .

Electric Broiler



Constant control of heat and cooking speed, plus savings in time and labor, are advantages claimed for the new Staltare Electric Broiler. This unique device, developed by an experienced chef, produces broiled food as it is ordered, without burning or loss of juices. Food is held at the desired temperature, cooks without watching or turning, and is delivered from the moving rack as ordered. It cannot be spoiled through forgetfulness on the part of the cook.

In the new Staltare Electric Broiler foods are cooked on both sides at the same time, thus cutting cooking time, eliminating turning and testing, and producing less shrinkage. The broiler is designed for quantity cooking but works efficiently for one order. The broiler is 56 inches high and is constructed of stainless steel. It is available as Model 1A with 30 inch diameter broiler, and as Model 1 with 40 inch diameter broiler for larger institutions. **Ace Welding Service, Dept. MH, 12 Newhall Ave., Saugus, Mass. (Key No. 227)**

Louvered Window

Seal-Vent Seal-Tested Jalousie windows are 100 per cent weatherstripped with new, lifetime vinyl plastic weatherstripping developed by the B. F. Goodrich Company. The new attractive, practical weather-tight louvered window features a "Seal-Frame" that seals the louvers against the weatherstripping when the window is closed, providing a tight closing that has had exhaustive tests to prove its weather-tightness under any conditions.

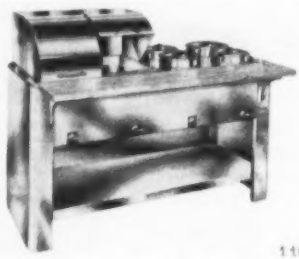
Extra heavy extrusion is used in the construction of the Seal-Vent Window. Inside screens are mounted flush for easy cleaning and storm sash attachments permit maximum ventilation on mild winter days. The windows are the result of three years of research and testing and feature unbroken lines to fit into any architectural design. **American Aluminum Products, Inc., Dept. MH, Miami, Florida. (Key No. 228)**

Water-Tube Steam Generator

The new Superior Water-Tube Steam Generator is a complete steam generating plant. Each unit is factory-assembled and test-fired for efficiency and capacity. Units are ready for operation with minimum installation expense. Built on a structural steel base, they require no brick setting, pitting or special foundation. They are designed to provide fully automatic firing with oil, gas or stoker coal and develop maximum efficiency with minimum supervision. Units are built in nine sizes with capacities ranging from 5300 to 33,000 pounds of steam per hour. **Superior Combustion Industries, Inc., Dept. MH, 1475 Broadway, New York 18. (Key No. 229)**

Waterless Food Warmer

The new Thermaduke Sanitary Waterless Food Warmer is available in a complete range of standard sizes. Models range from small buffet warmers to complete cafeteria counters, including portable food warmers for institutional use. Installations require no water or drain conections and there is no water pan to empty and clean. Selective heat



control permits regulation of heat by section to give proper temperature for each type of food. Top plates are interchangeable and are available for any desired top arrangement.

The new models are ruggedly constructed of all-welded steel, available in stainless steel or baked gray enamel finishes. Corners are rounded and polished and the line is designed for easy cleaning and maintenance, low operating costs and low heat loss and humidity. **Duke Manufacturing Co., Dept. MH, 2305 N. Broadway, St. Louis 6, Mo. (Key No. 230)**

Safety Mug

Designed especially for use in mental hospitals, children's wards and other areas of the hospital where breakage is a problem, the No. 126C Safety Mug is shockproof, stain resistant and light in weight. It is in a simple mug shape with a large, easy-to-hold handle and does not retain odors. **Victory Plastics Co. Dept. MH, Hudson, Mass. (Key No. 231)**

(Continued on page 270)

Pedia-Treat Tongue Blades

Oral examination of infants and children is facilitated with the new Pedia-Treat Tongue Blades now available. Individually wrapped, the tongue depressors are candied at one end with pure sugar and water, plus assorted flavorings. **Marvin R. Thompson, Inc., Dept. MH, 67 Greenwich Ave., Stamford, Conn. (Key No. 232)**

Gas-Fired Incinerator

A new twin-burner, gas-fired incinerator for institutional use in disposing of rubbish is offered in the B-42 Incinor. The new incinerator has a four bushel capacity and uses LP, manufactured, natural or mixed gases as fuel. The burners have manual push-button lighters and baso-thermocouple valves for safety. It is designed to solve institutional disposal problems efficiently and economically and combustion takes place rapidly with a minimum of smoke. The top opening is 12 by 18 inches. **Bowser, Inc., Incinerator Div., Dept. MH, Cairo, Ill. (Key No. 233)**

Wide Louver Vertical Blinds

The problem of covering unusually wide-spanned windows can be solved with the new 5¾ inch wide louver Vertical Blinds. They operate in the same manner as standard 3 inch Vertical Blinds, with a hand-operated or motor-controlled rod which rotates from fully open to closed.

Vertical Blinds combine the decorative qualities of draperies, curtains and blinds while controlling the flow of both light and air through rotation of the fabric louvers. They are available in Du Pont fabrics in a variety of colors. Maintenance and cleaning are reduced as the blinds collect a minimum of dust be-



cause of the vertical surfaces. **Vertical Blinds Corp. of America, Dept. MH, 1936 Pontius Ave., West Los Angeles 25, Calif. (Key No. 234)**

Woodard style authority in wrought iron



THIS IS OUR SKYLINE...

WROUGHT IRON . . . designed especially for indoor use.
Good-looking, to be sure . . . and ever so practical. The chairs have stainless steel glides encased in rubber to protect your floors.
The glass table-tops rest on patented rubber cushions set into table frames, eliminating noise and breakage.
The sectional seating units are designed so they can be attached by a single standard bolt and nut to produce an integral unit of any combination of sections. Shown here covered in Duran . . . which is resistant to water, alcohol, oil, grease and fading.

LEE L. WOODARD SONS OWOSSO, MICHIGAN

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NEW YORK: ONE PARK AVENUE
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There's *extra protection* for you in POLAR WARE stainless steel Clinical Utensils



SEAMLESS construction in Polar Ware stainless steel provides an extra measure of assured sterility in washing. This plus value is reinforced by many other positive qualities in these almost indestructible clinical utensils. Antiseptics, medicines, soaps, detergents affect them not at all. Neither do high or low temperatures. In a phrase, these ever-lasting advantages offer you a bedrock economy of maintenance unmatched by anything else that you buy.

The doctor in the operating room, the pharmacist in the dispensary, the patient in the sickroom, all accept these clinical utensils with a confidence anchored on years of time-tested performance. Polar Ware has pioneered this recognition . . . has since 1926 produced stainless steel ware to the exacting requirements of hospital service. No other manufacturer has known this specialized field longer, or better — or provides a more complete line. That's why the leading supply houses from coast to coast feature Polar Ware. They make it their business to give you the best. Ask the men who call on you.

A catalog showing the complete Polar Ware line is yours for the asking.

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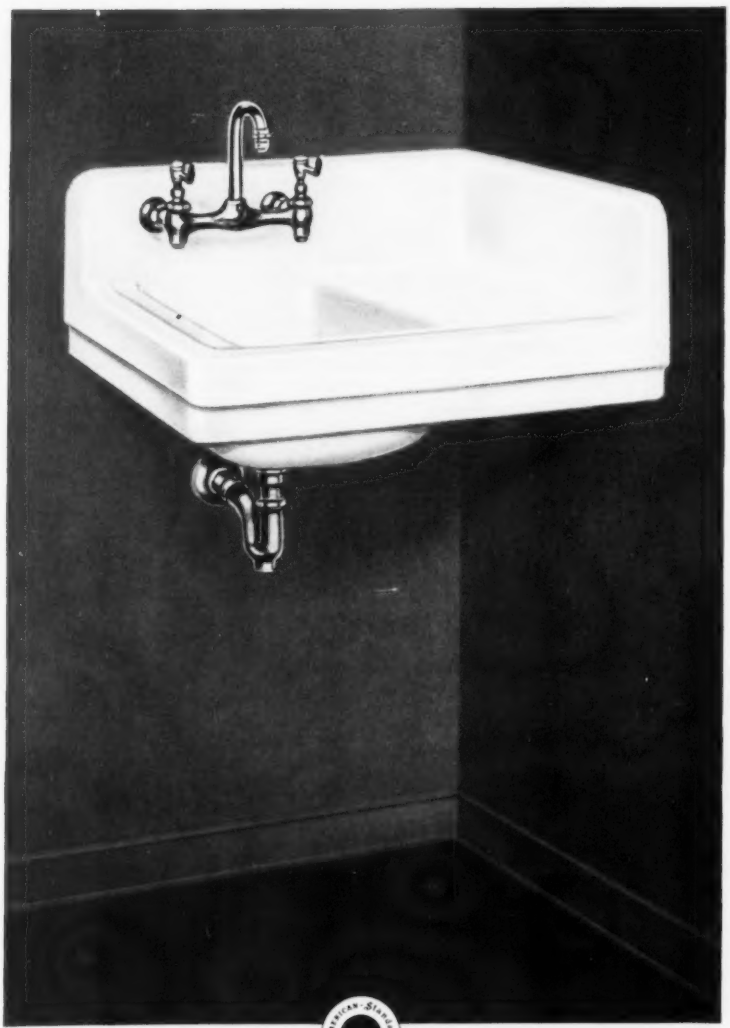
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In hospital rooms . . . doctors' offices . . . small rooms

new AMERICAN-Standard lavatory puts corner space to practical use





■ The new American-Standard corner lavatory (HF 12203 LA shown) meets small space requirements with complete convenience features. It is only 26 x 20 inches in size . . . can put wasted corner space to practical use.

Designed for convenience in use, this compact fixture offers a handy integral drainboard and bowl and six-inch high splash back to protect walls. Genuine vitreous china construction assures complete sanitation — it is non-absorbent, easy to care for, won't become permanently stained. Wrist control faucet handles permit washing without hands touching fitting. Gooseneck spout has Spring-Flo aerator to prevent splashing. All fittings are bright, non-tarnishing Chromard.

For flexibility of installation, the new American-Standard corner lavatory is available with drainboard on either left or right side. Your architect or plumbing contractor can give you full details.

AMERICAN-Standard

American Radiator & Standard Sanitary Corporation, P. O. Box 1226, Pittsburgh 30, Pa.

Serving home and industry

AMERICAN-STANDARD • AMERICAN BLOWER • CHURCH SEATS & WALL TILE • DETROIT CONTROLS • KEWANEE BOILERS • ROSS EXCHANGERS

What's New . . .

Model K Floor Machine



A low priced, yet sturdy, effective floor cleaner is offered in the new Hild Model K Floor Machine. It is equipped with a powerful ⅓ h.p. heavy duty vertical motor which requires no lubrication. The 12½ inch brush spread and brush speed of 210 r.p.m. assure lively action for a hard finish on all waxed surfaces. The machine operates quietly and has an efficient new power transmission system. It has a steel base with baked-on enamel crinkle finish and is fitted with a bumper of non-marking gray plastic. The handle of steel tubing is fitted with rubber grips and a cast aluminum switch box. Attachments are available to scrub, wax, polish, buff, sand and steel-wool floors of all kinds. **Hild Floor Machine Co., Dept. MH, 740 W. Washington Blvd., Chicago 6. (Key No. 235)**

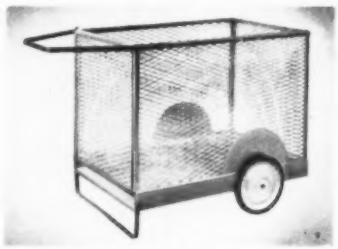
Orthopedic Felt

A convenient self-dispensing container is provided with the new Profex Standard Orthopedic Felt developed by Professional Specialties. The new wool felt meets all requirements of the National Bureau of Standards and the Department of Commerce, according to the manufacturer. The felt is designed for use in bandages, tourniquets, harnesses, surgical splints, casts, diathermy equipment, blood transfusion apparatus and other applications. The dispensing package minimizes the handling necessary in cutting desired lengths and keeps the felt clean. The felt is available in ½ and ¼ inch thicknesses, in either white or gray. **Professional Specialties, Inc., Dept. MH, 1330 Dolman St., St. Louis 3, Mo. (Key No. 236)**

Portable Leaf Burner

One of the problems soon to be faced in the maintenance of grounds can be facilitated through use of a new portable leaf burner recently introduced. It provides a safe way to dispose of all dry burnable refuse at any time of year, including leaves, papers, twigs, brush and grass cuttings. Mounted on wheels, the Lazy Andy Portable Leaf Burner can be brought to the place of need, eliminating tiresome trips to a burning pile.

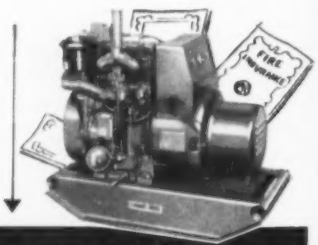
Constructed of heavy gauge steel, the burner is designed to stand up under years of use. It is painted aluminum to deter rust and has bright orange wheels which are steel-based and covered with wide rubber tires to protect the lawn. The tires are shielded against even sustained intense heat. The unit can be easily pushed or pulled from place to place. It has a heavy gauge steel ash collector below the burning basket which is easily emptied. The whole unit can



be quickly disassembled into a 3 inch wide package for storage. **Gardening Products, Inc., Dept. MH, 519 Forest St., Arlington, N.J. (Key No. 237)**

(Continued on page 274)

What about "NO PANIC" INSURANCE?



. . . a FAIRBANKS-MORSE Stand-By Power Generating Set!

When the lights stay on, elevators run and other automatic machinery keeps working, chances for panic, injuries and loss of life are greatly reduced. That's why stand-by electric power generating sets are a *must* for schools, hospitals, theaters, municipal buildings and other places where large numbers of people assemble.

If you do not have that kind of "panic insurance," let us send you the facts, free, about Fairbanks-Morse generating sets. They are available in capacities up to 40,000 watts. Write Fairbanks, Morse & Co., 600 S. Michigan Ave., Chicago 5, Ill.

FAIRBANKS-MORSE
a name worth remembering when you want the best

WATER SYSTEMS • GENERATING SETS • MOWERS • HAMMER MILLS • PUMPS
MAGNETOS • MOTORS • SCALES • DIESEL LOCOMOTIVES AND ENGINES

It's the GENNETT ICE CART



Stainless Steel INSIDE AND OUT

Write for FREE CATALOG

MODEL XV
150 lb. capacity

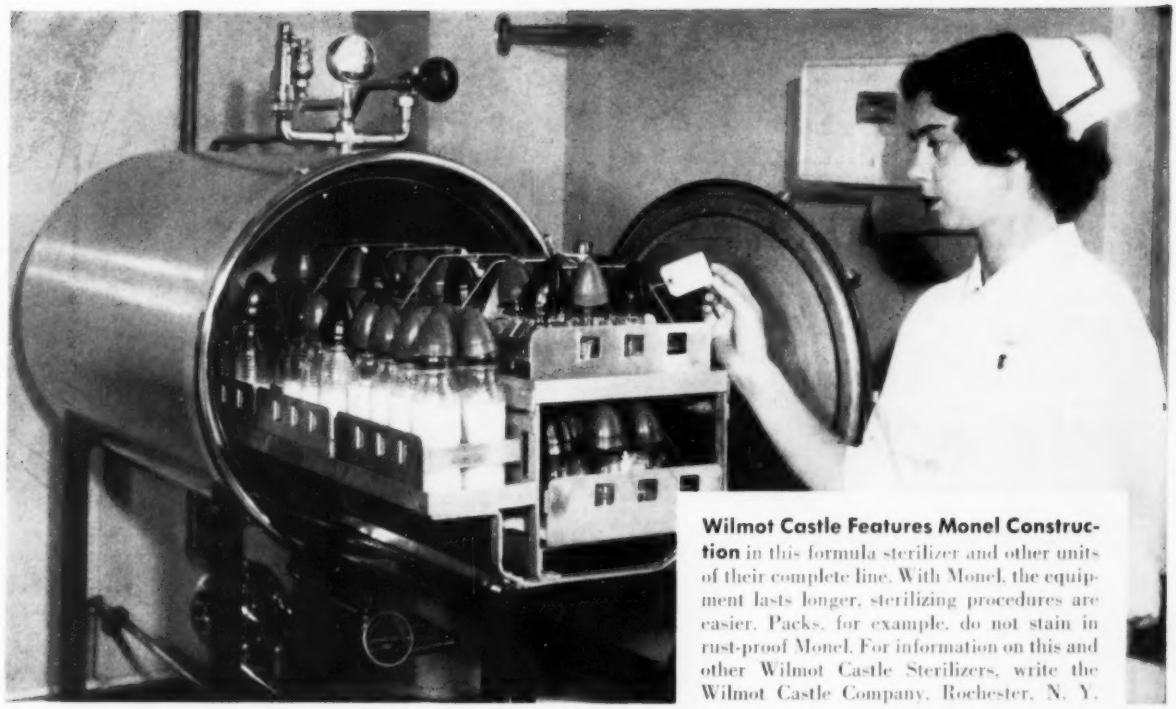
Right . . . the Model XV is the answer! Stainless Steel construction throughout, for DURABILITY.

Three-inch thick insulation keeps your profits from melting away.

Made in 3 sizes—50, 75 and 150-lb. capacities.

Keep pace with the well-equipped institution . . . Go Gennett!

GENNETT AND SONS, INC.
Richmond, Ind.



Wilmot Castle Features Monel Construction in this formula sterilizer and other units of their complete line. With Monel, the equipment lasts longer, sterilizing procedures are easier. Packs, for example, do not stain in rust-proof Monel. For information on this and other Wilmot Castle Sterilizers, write the Wilmot Castle Company, Rochester, N. Y.

What does a Charge Nurse say...

about the construction of sterilizers?

A woman, sometimes, is disconcertingly direct and practical.

A charge nurse, for example, is impatient with details of sterilizer construction that concern you.

What she wants to know is, "Will it give me any trouble?" She'll let you worry about how the unit is made.

But relax. When inner pressure chambers are Monel®, a host of sterilizer troubles simply disappear. Look what Monel does to immunize this Wilmot Castle unit against common problems.

Look first at the Monel surface. Dirt is hard put to find a lodging place on a surface so smooth. And Monel surfaces stay smooth for years. Monel is too hard and tough to scratch or dent easily. It doesn't pit easily, either. For Monel resists corrosion by lactic and other acids, by alkalies, by saline solutions.

If dirt should cling to a Monel surface, it can usually be wiped off with a damp cloth. But you may use detergents or mild abrasives freely. Monel is solid all the way through and cleansers don't harm it nor do they destroy its corrosion resistance.

In fact, there is little anyone can do to harm Monel. Sterilizing pressures and temperatures don't hurt Monel (it withstands much tougher conditions in steam power plants, for example). Monel is not subject to stress-accelerated corrosion. It can't rust, can't dezincify. Even rapid and repeated variations in pressure and temperature do not affect Monel adversely.

Monel stops trouble before it starts, keeps charge nurses contented. Veteran sterilizers made of Monel still look and perform as well as they did when installed 10 or 15 years ago.

So make sure the sterilizers you buy are immunized by Monel against metal troubles.

Remember, however, that since Monel is needed for many critical military uses, it is on extended delivery for civilian use. It pays to order Monel sterilizers well in advance of your need.

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street **New York 5, N. Y.**

Inco Nickel Alloys INCO **Monel**... *for immunized sterilizers*

insist on the genuine in the

FOIL-ENVELOPE

with genuine

SEALED-IN STERILITY



In the manufacture of 'Vaseline' Sterile Petrolatum Gauze Dressings, especially designed equipment, especially trained personnel, especially planned techniques, and especially rigid control tests assure absolute sterility. Heat-sealed foil-envelopes safeguard this sterility under all normal conditions of storage for an indefinite period.

These many precautions cannot be duplicated in the extemporaneous preparation of petrolatum gauze . . . and the usual result is a dressing of uncertain sterility. Sterility is of the first order, so is its assurance.

It's Always Sterile . . . Always Ready for '1001' surgical uses

Three convenient sizes:

No. 1 – 3" x 36" strips (6 in carton)
No. 2 – 3" x 18" strips (12 in carton)
No. 3 – 6" x 36" strips (6 in carton)

VASELINE is the registered trade-mark of the Chesebrough Mfg. Co., Cons'd

CHESEBROUGH MFG. CO., CONS'D
Professional Products Division
NEW YORK 4, N.Y.

Vaseline
TRADE-MARK ®
Sterile Petrolatum Gauze Dressings

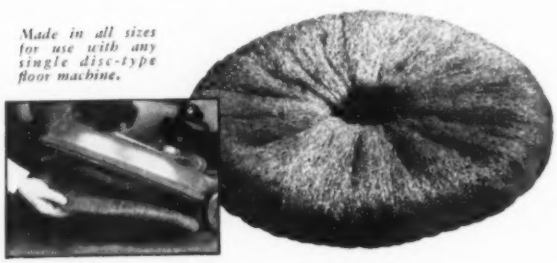


Sun Ray WOOLERS make *all* floors . . .

"clean enough to eat off of"

The fast, thorough, dry-scrubbing action of Sun Ray WOOLERS produces smooth, lustrous and immaculate floors! Long, strong strands of *radially* wound steel wool always rotate at right angles to attack dirt. This exclusive Sun Ray feature assures fast, efficient "steel wooling."

Made in all sizes for use with any single disc-type floor machine.



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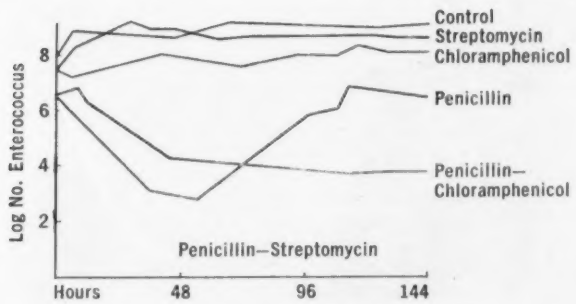
Sun Ray ANOTHER STEEL WOOL PRODUCT MANUFACTURED BY

THE WILLIAMS COMPANY

250 West First Street, London, Ohio

New

high potency antibiotic combination with a broad antibacterial spectrum



–After Jawetz, A.M.A. Arch. Int. Med. 90:301, 1952, and Hunter, Bull. New York Acad. Med. 28:213, 1952.

- Effective against gram-negative and gram-positive organisms–valuable in mixed or undiagnosed infections.
- Synergistic effect has been demonstrated against certain organisms. This may be useful in resistant infections.
- Correct proportions–each dose supplies the maximum amounts of penicillin and streptomycin drugs usually prescribed.
- Safe–since streptomycin and dihydrostreptomycin are present in equal amounts, the dose of each drug is relatively small, and ototoxicity is seldom encountered.
- Well tolerated–sensitivity reactions are rare.
- Ready to inject as supplied.
- Stable for one year if stored below 15° C.

CRYSDIMYCIN A.S.

per dose { 600,000 units procaine penicillin G suspended in an aqueous solution of streptomycin and dihydrostreptomycin sulfates, 0.5 Gm. each

Supplied in 5 dose vials

SQUIBB a leader in the research and manufacture of penicillin and streptomycin

'CRYSDIMYCIN' IS A TRADEMARK

What's New . . .

Pharmaceuticals

Radioactive Iodinated Blood Albumin

RISA, radioactive iodinated blood albumin, is a new research and diagnostic tool with clinical application in cases of burns and shock. The compound provides a rapid yet reliable means of determining whether blood or other fluids need to be replaced in the body and the quantity of solution that should be administered. It is also used in studies of the circulation of the blood. Approval for production of radioactive iodoalbumin has been granted to Abbott by the National Institute of Health, a division of the U.S. Public Health Service. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 238)**

Dibenzyline

Dibenzyline is a new, orally effective adrenergic blocking agent for the treatment of peripheral vascular disorders and hypertension of pheochromocytoma. It increases peripheral blood flow, raises skin temperature, relieves causalgic pain and lowers both supine and erect blood pressures. **Smith, Kline & French Laboratories, Dept. MH, 1530 Spring Garden St., Philadelphia 1, Pa. (Key No. 239)**

Kectil

Kectil is a combination of penicillin, streptomycin and sulfaguanidine with bismuth, Keolin and pectin. It is indicated for the comprehensive treatment of specific and non-specific diarrheas. It is supplied in bottles containing sufficient powder to prepare four fluid ounces of a pleasant tasting suspension at a time, by the addition of water. After reconstitution, the preparation will be stable for seven days in refrigeration. **Bristol Laboratories Inc., Dept. MH, Syracuse, N. Y. (Key No. 240)**

Roncovite

Roncovite contains therapeutic cobalt with ferrous sulfate for specific bone marrow stimulation in anemia. Medical research has indicated that therapeutic doses of cobalt exert a consistent and pronounced hematopoietic effect on bone marrow. Roncovite is described as having a rapid stimulating effect on the human blood-producing mechanism. It is supplied in tablet form in bottles of 100 and in drop form, for dilution with water, milk, fruit or vegetable juice for administration to children, in bottles of 15 cc. with calibrated dropper. **Lloyd Brothers, Inc., Dept. MH, 1016 Mound St., Cincinnati 3, Ohio. (Key No. 241)**

Provell Maleate

Provell Maleate is described as a pure, highly potent but safe drug for the treatment of all forms of high blood pressure. It is the crystalline maleate salts of protoveratrines A and B, two virtually identical alkaloids of the white hellebore. The elimination of inactive constituents makes the product highly potent and its activity in the individual patient predictable. It has proved effective in lowering blood pressure and has a safety factor as overdose will produce nausea. **Eli Lilly and Company, Dept. MH, Indianapolis 6, Ind. (Key No. 242)**

Stilbamidine

Stilbamidine is a new therapeutic agent for the treatment of systemic fungus diseases. It is one of the diamidine drug series and has been used effectively in the treatment of blastomycosis and leishmaniasis. Also it has been used as palliative treatment of multiple myeloma. The product must be given only under careful medical supervision and solutions should be freshly prepared for each use and protected from light. It is administered by intravenous injection with a continuous slow drip. **The Wm. S. Merrell Co., Dept. MH, Cincinnati 15, Ohio. (Key No. 243)**

(Continued on page 276)

KENWOOD MAKES GOOD BLANKETS!

GOOD BLANKETS MAKE PATIENTS COMFORTABLE, SAVE HOSPITALS MONEY

KENWOOD TEXTILE PRODUCTS

Kenwood blankets are sold only by Kenwood salesmen or direct from Kenwood Mills. Send today for swatches, prices and full information.

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Dexter Diapers

The diaper that does away with half the work in your laundry and nursery.

BECAUSE

Dexter Diapers eliminate all folding in your laundry and nursery.

SPECIAL LOW PRICE TO HOSPITALS
Write direct to manufacturer or ask your favorite diaper service.

Most popular diaper used today in hospitals over the nation . . . from local diaper services or in their own laundry.

DEXTER DIAPERS

Ask Your Favorite Diaper Service, Department Store or Baby Shop.

SEND 25c TO
FRED DEXTER, MFR
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FOR 1. Sample Diaper 2. Pins-on-Chains 3. Helpful Booklet
ALL 3 FOR ONLY 25c
IDEAL BABY SHOWER GIFT
We Lose Money On This Offer





ENDURO EQUIPMENT means Less Hospital "Clean-up" Time

The sparkling, sanitary freshness of these two hospital installations speaks authoritatively for the cleanability of ENDURO Stainless Steel. And these gleaming results are accomplished easily—with little cleaning time!

Less hospital "clean-up" time . . . there's a thought worthy of careful consideration by hospital administrators who know only too well how valuable time can be effectively used elsewhere.

ENDURO equipment is remarkably easy to clean—and *keep* clean. A simple, fast water rinse and a wipe usually restores its glassy-smooth surface to original, ultra-clean lustre. Stainless steel offers little or no foothold for foreign materials.

The new-looking instrument cabinets, illustrated, were installed about 14 years ago. Their future is still bright! Absence of scratches, dents, discolorations and buckling attests the toughness and long lifespan of rust and corrosion-resistant, wear-resistant, easy-to-clean ENDURO.

With your housekeeping, time-saving and cost-cutting problems in mind, hospital suppliers are making more and more equipment items of ENDURO. Check with them, or write us for more information:

REPUBLIC STEEL CORPORATION
Alloy Steel Division • Massillon, Ohio
GENERAL OFFICES • CLEVELAND 1, OHIO
Export Department:
Chrysler Building, New York 17, N. Y.

Republic
REPUBLIC STEEL
ENDURO® STAINLESS STEEL

Other Republic Products include Carbon and Alloy Steels—Pipe, Sheets, Tubing, Lockers, Shelving, and Fabricated Steel Building Products

What's New . . .

Product Literature

• A folder has been published by Parke, Davis & Co., Detroit 32, Mich., containing the first four in its new series of public service advertisements, **"Your Doctor And You." (Key No. 244)**

• **"Suggestions to Make Your Gloves Last Longer"** is the title of a new folder prepared by The Massillon Rubber Company, Massillon, Ohio. The data compiled from tested procedures in hospitals where proper purchasing, storing, washing, testing and sterilization of gloves is followed, indicates that hospital expenditures on surgeons' gloves can be substantially reduced where proper procedures are practiced. Animated drawings illustrate the major suggestions. The folder is offered to the hospital administrator for distribution to all personnel who handle surgical gloves. **(Key No. 245)**

• A series of nationally uniform sanitation standards for food service and other health-related equipment is being undertaken by the National Sanitation Foundation, University of Michigan School of Public Health, Ann Arbor, Mich. The third in the series, **"NSF Standard No. 3, Spray-Type Dishwashing Machines,"** is now available. It is the result of more than two years of work on the part of Foundation committees on methods of washing dishes, utensils and glasses satisfactorily from the health point of view. **(Key No. 246)**

• Applications of the **American ALM-13 floor maintenance machines** are shown through a series of on-the-job action photographs in a new 4 page catalog issued by American Floor Surfacing Machine Co., 518 S. St. Clair St., Toledo 3, Ohio. The ALM-13 is an economy machine for smaller areas and provides dependable performance for a wide range of operations on all types of floors. Specifications and other technical data are included in the new catalog. **(Key No. 247)**

• The 12 page **Catalog G2-2,** which illustrates and describes Guilbert Alsteel bi-parting, telescoping and single section freight doors for use on hospital elevators, has recently been published by Guilbert, Inc., 1105 Frankford Ave., Philadelphia 25, Pa. Also included is information on Guilbert Alsteel Dumbwaiter Doors. **(Key No. 248)**

• **Supplement No. 3 to Catalog No. LP-31,** Laboratory Glassware, is now available from Corning Glass Works, Corning, N.Y. The new supplement lists the products alphabetically, with prices. **(Key No. 249)**

• The attractive line of Huntington Institutional Furniture is illustrated and described in **Catalog No. 104** issued by Huntington Chair Corporation, Huntington, W. Va. Photographs illustrate the furniture, for nurses' homes and other residence buildings, which is constructed of fine Appalachian Oak. **(Key No. 250)**

• Information on both ladder and rolling types of aluminum scaffolding is offered in a new folder published by The Patent Scaffolding Co., Inc., 38-21 12th St., Long Island City 1, N. Y. **Bulletin AS-2** gives specifications and illustrations of some of the structures possible with the various sections of aluminum scaffolding, pictures of actual installations, and general information on the handling and safety features of this equipment. **(Key No. 251)**

• A series of "How To" maintenance booklets has been issued by Red Devil Tools, Irvington 11, N. J. The three booklets cover **"How to Cut Glass," "How to Fix Broken Windows"** and **"How to Maintain Wood Floors."** Each step in the process described is covered by instructive text with a carefully done illustration of the application. The booklets should be helpful as instructive material for maintenance employees. **(Key No. 252)**

(Continued on page 278)



Sofa, 53" wide, Fawn Oak 181



Chest, Fawn Oak 820

Furniture by **HUNTINGTON**

– always in good Taste

Huntington high quality furniture is specifically designed for long wear and style appeal for every institutional use — lounging areas, sleeping quarters and executive offices. Both the quality and comfort are guaranteed by strict adherence to high standards of manufacturing. Sold through authorized contract dealers. Designs by Jorgen Hansen and Jens Thuesen.

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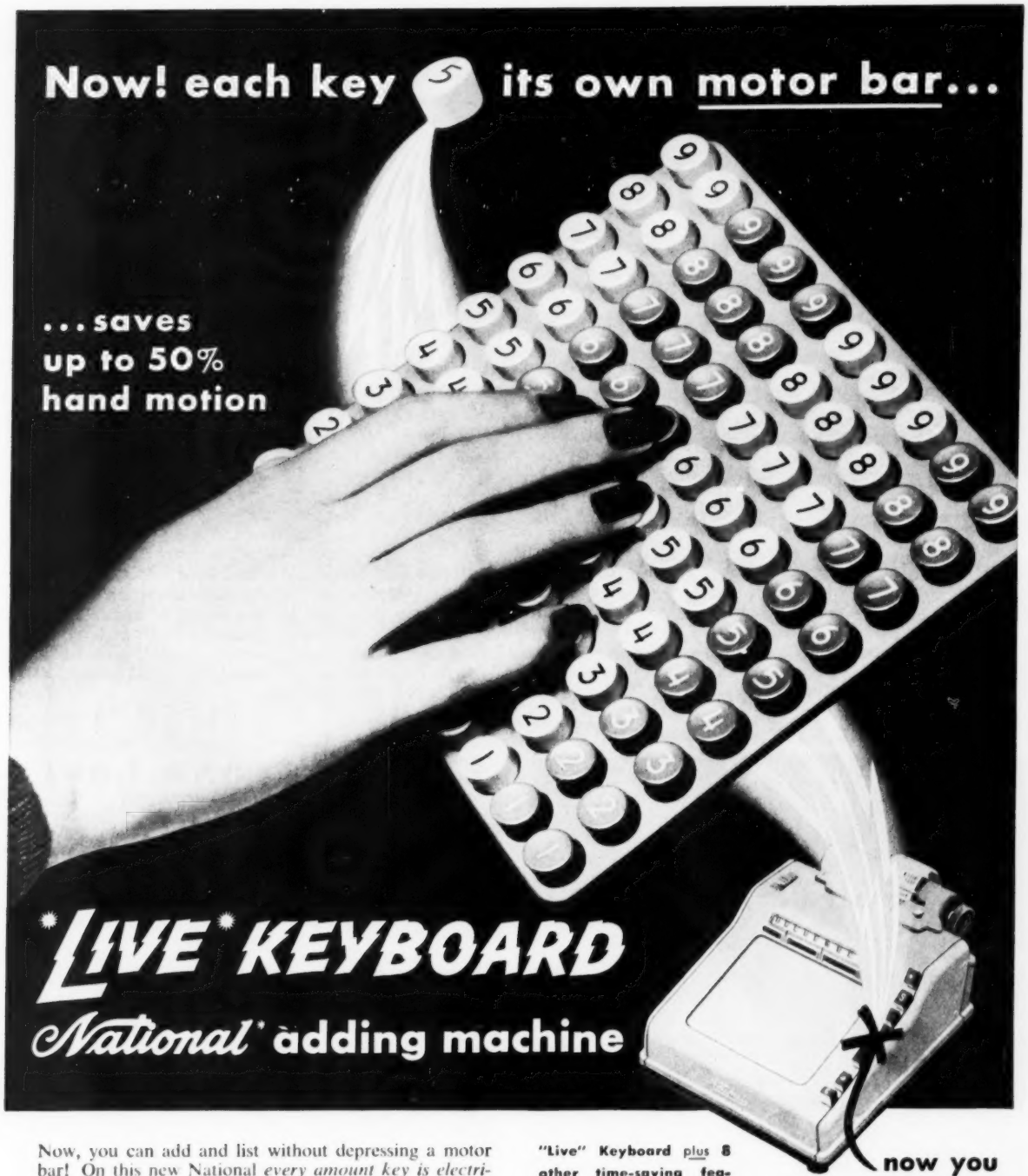
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BOSTON • CHICAGO • DALLAS • PHILADELPHIA • SAN FRANCISCO • WHITNEY, S. C.



Now, you can add and list without depressing a motor bar! On this new National *every amount key is electrified!* Simply press the keys you want to add—the machine does it instantly! *You save up to 50% hand motion.*

National's "feather-touch" action makes it easier than ever to press two or more keys at once—more time-saving! All ciphers print automatically—still more time saved! Operators like it—they do their work with so much less time and effort.

Printed words cannot explain all the advantages of this "Live" Keyboard. You must see it to believe it. See it today!

For demonstration phone nearest National office or National dealer

"Live" Keyboard plus 8 other time-saving features combined only on National: Automatic Clear Signal • Subtractions in red • Automatic Credit Balance • Automatic space-up of tape when total prints • Large Answer Dials • Easy-touch Key Action • Full-Visible Keyboard, Automatic Ciphers • Rugged-Duty Construction.

now you can forget the motor bar!

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National

ADDING MACHINES • CASH REGISTERS
ACCOUNTING MACHINES

THE NATIONAL CASH REGISTER COMPANY, DAYTON 9, OHIO

What's New . . .

• A Revised Edition of **Bulletin 2589** on **Explosion-Proof Condulet Electrical Equipment for Hospital Operating Rooms** has been issued by Crouse-Hinds Company, Syracuse 1, N. Y. The 28 page bulletin describes wiring devices, installation methods and types of explosion-proof condulets for use in protecting electrical outlets, switches and other fixtures from the explosive effects of anesthetic gases or liquids. **(Key No. 253)**

• The new 40 page **Melrose Catalog** illustrates and describes apparel for hospital personnel. Included are accessories for the hospital operating room, binders, patients' gowns, uniforms for doctors, laboratory personnel and nurses, as well as orthopedic specialties, canvas and leather restraints and conductive rubber slippers. The catalog is available from Melrose Hospital Uniform Co., Inc., 95 Commercial St., Brooklyn 22, N. Y. **(Key No. 254)**

• The complete line of institutional laundry equipment manufactured by The Prosperity Company, Inc., Syracuse, N. Y., is illustrated, and described in five languages, in a new booklet recently released. Each piece of descriptive copy appears in five languages in what the company terms its **"International Complete Line Manual." (Key No. 255)**

• **"Midland Maintenance and Sanitation Products"** are described in a new catalog issued by Midland Laboratories, Dubuque, Iowa. The catalog is indexed and includes descriptive information and uses of soaps, seals, finishes, removers, waxes, disinfectants, deodorants, insecticides and sprayers, dishwashing aids, floor machines and other maintenance equipment and supplies. **(Key No. 256)**

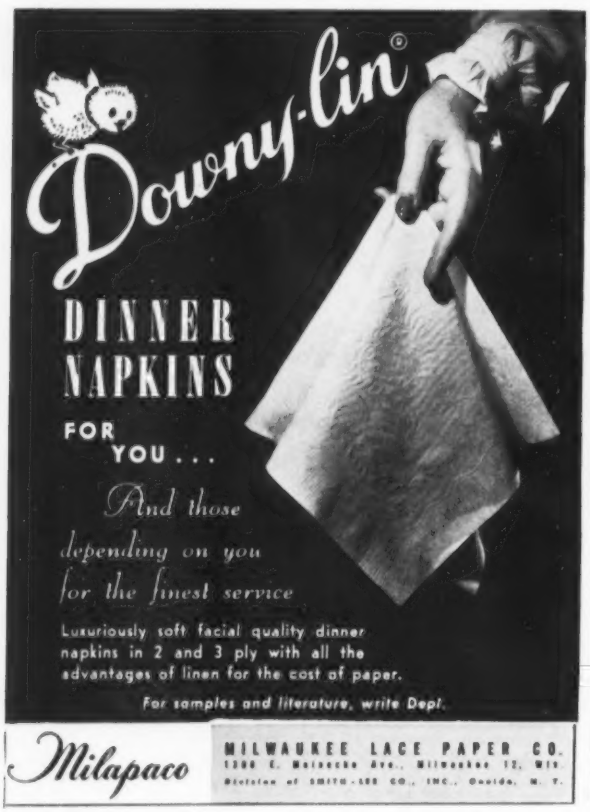
• Cork back bulletin boards, directional signs, plastic protective spray, bronze tablets and signs, letters in all materials and many other items are illustrated and described in the new **Catalog No. 41** issued by Spencer Industries, 1508 N. Mascher St., Philadelphia 22, Pa. The various sizes and types of sign material are discussed. General information on all fabricated letters and on fastening methods for metal letters is covered fully. **(Key No. 257)**

• Descriptive details of the **Rocke Hospital Bed "Sit-Up" Chair** are given in a new folder prepared by Wm. Rocke Co., Inc., P. O. Box 623, Bloomington, Ill. How this comfortable back rest for bed patients is attached to the bed, how it is used by the patient and the ease with which it is carried and stored are pictured and discussed. Information is also given on the Rocke Hydrotherapy Baths in this illustrated leaflet. **(Key No. 258)**

• A most attractive handbook, entitled **"Let's Look at the X-Ray Department,"** has been prepared by the Picker X-Ray Corp., 25 S. Broadway, White Plains, N.Y. The book digests the story of the x-ray department in easy terms so that the non-technical personnel on the staff, board and in other departments of the hospital can be helped to understand the physical plant and functional operation of the hospital x-ray department. The text covers the need for x-ray equipment, how x-rays are used in diagnosis and treatment, the various kinds of x-ray machines and what they do, how radiographs are processed, the matter of protection, and department layout. **(Key No. 259)**

• **"The Precision Line . . . Metal Furniture with Plastic Webbing"** is the title of a new folder issued by Precision Mfg. Co., Evanston, Ill. Featured are chairs and tables of metal in attractive modern design for reception rooms, lounges, solariums, nurses' homes and other areas of the hospital. Removable plastic webbing is attached to the metal chair frames by a patented clip. Colors can be changed as desired and the chairs are comfortable and inexpensive. The frames are available in chrome or baked enamel and the plastic webbing in red, green or ivory or in special colors on order. **(Key No. 260)**

(Continued on page 280)





REVOLUTION ON THE SKYLINE



MEDICAL CENTER—UNIVERSITY OF CALIFORNIA at Los Angeles

ARCHITECTS: WALTER WURDEMAN and WELTON BECKET & ASSOCIATES, F.A.I.A. Los Angeles

FUNCTIONAL! BEAUTIFUL! Sealuxe

The vast Medical Center of the University of California at Los Angeles, when completed will be one of the greatest, most modern medical meccas of the world.

Universal is instrumental in making this both a functional and beautiful center with its planning and manufacture of metal glass-facades that are revolutionizing the nation's skyline.

Universal's Field Erection Department is now installing the SEALUXE Browne Folding Flue Window, Model 10-A, in this Medical Center. The ventilating qualities of this vented fixed window are such that it can be used alternatingly and still obtain adequate ventilation. Universal is also furnishing the stools, interior and exterior trim. Each bay of windows is framed in SEALUXE dormer trim.

Sealuxe

Engineered Accessories!

- **Browne "Folding Flue" Windows**
- **Ventilating Picture Windows**
- **Cellular Spandrels and Fascias**
- **Rectangular Fins**
- **Dormer Surrounds**
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- **Canopies (Eyebrows)**
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UNIVERSAL can help solve your design and engineering problems. Authorized agents are in ALL of the Architectural Centers to assist you.

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ENGINEERING • MANUFACTURING • INSTALLATION

J. P. TRAVIS, *President*, Creator of *"Miracles in Metals"*

What's New . . .

• Illustrations, cut-away views and informative text tell the story of the **Tri-Saver Coffee System** in the new comprehensive handbook issued by S. Blickman, Inc., Weehawken, N. J. All types of urns used in the Tri-Saver System are illustrated and described and the book gives detailed specifications for the complete line. Sizes and roughing-in dimensions are also included. **(Key No. 261)**

• **"The First One Hundred Years"** of Otis Elevator service is told, with illustrations, in a 44 page booklet issued by Otis Elevator Co., 260 Eleventh Ave., New York 1. Told like a story, the editorial text is illustrated with old pictures of early buildings, the first passenger elevators and freight elevators, early advertising and other interesting historical material. **(Key No. 262)**

• **Castaloy Laboratory Appliances** are discussed in a booklet published by Fisher Scientific Company, 717 Forbes St., Pittsburgh 19, Pa. The booklet is artistically laid out with illustrations and text well balanced on each page. The information provided is complete yet concise. **(Key No. 263)**

• Four reasons why effective grease interception saves time and money are listed in a new technical guide of the proper sizing and selection of grease interceptors published by the J. A. Zurn Mfg. Co., Erie, Pa. **Technical Bulletin 6-52** gives text and detailed charts describing how capacity of grease interceptors is determined. A simple checklist for determining types to be used supplements descriptive text, charts and specifications. **(Key No. 264)**

THIS COUPON is provided for your convenience in requesting additional information.

- ☐ 198 Oxygen Timer
- ☐ 199 Surgical Gut
- ☐ 200 Full Random Cushiontone
- ☐ 201 Overhead Fracture Frame
- ☐ 202 Dishwashing Detergent
- ☐ 203 Conductive Tester
- ☐ 204 Mobile Commode
- ☐ 205 Fixture Hanger
- ☐ 206 Hot Water Boiler
- ☐ 207 Collapsible Coat Racks
- ☐ 208 Commodore Plaid Blankets
- ☐ 209 Binding Punch
- ☐ 210 Color Coding for Sponges
- ☐ 211 Kimble Toplite System
- ☐ 212 Hospitality Light
- ☐ 213 X-Ray Protective Apron
- ☐ 214 Windall Sills
- ☐ 215 Boiler-Burner Unit
- ☐ 216 Easy Finisher
- ☐ 217 Floor Tile
- ☐ 218 X-Ray Illuminator
- ☐ 219 Floor Machine
- ☐ 220 Silent Mop Wringer
- ☐ 221 Sanitary Disposable Slippers
- ☐ 222 Contact Deodorant
- ☐ 223 Visible Filing Equipment
- ☐ 224 Humi-Tent
- ☐ 225 Surface Coating
- ☐ 226 Label Holder
- ☐ 227 Electric Broiler
- ☐ 228 Jalousie Windows
- ☐ 229 Steam Generator
- ☐ 230 Waterless Food Warmer
- ☐ 231 Safety Mug
- ☐ 232 Tongue Blades
- ☐ 233 Incinerator
- ☐ 234 Vertical Blinds
- ☐ 235 Floor Machine
- ☐ 236 Orthopedic Felt
- ☐ 237 Portable Leaf Burner
- ☐ 238 Iodinated Blood Albumin
- ☐ 239 Dibenzyline
- ☐ 240 Kectil
- ☐ 241 Roncovite
- ☐ 242 Provell Maleate
- ☐ 243 Stilbamidine
- ☐ 244 "Your Doctor and You"
- ☐ 245 "Make Gloves Last Longer"
- ☐ 246 Dishwashing Machine Standards
- ☐ 247 Floor Maintenance Catalog
- ☐ 248 Catalog G2-2
- ☐ 249 Laboratory Glassware Catalog
- ☐ 250 Catalog No. 104
- ☐ 251 Bulletin AS-2
- ☐ 252 "How To" Folders
- ☐ 253 Bulletin 2589
- ☐ 254 Hospital Apparel Catalog
- ☐ 255 Laundry Machinery Manual
- ☐ 256 Maintenance Catalog
- ☐ 257 Catalog No. 41
- ☐ 258 "Sit-Up" Bed Chair
- ☐ 259 X-Ray Handbook
- ☐ 260 "The Precision Line"
- ☐ 261 Coffee System
- ☐ 262 "First One Hundred Years"
- ☐ 263 Castaloy Laboratory Appliances
- ☐ 264 Technical Bulletin 6-52
- ☐ 265 Book Announcements

I should also like to have information on the following products

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NAME **TITLE**

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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

Book Announcements

Frobisher, "Fundamentals of Microbiology," 5th ed., 633 pp., $6. Glass and Hamrum, "Anatomy and Physiology Laboratory Manual," 57 pp., $1.50. Krueger, "Principles of Microbiology," 648 pp., $5.50. Luder, Vernon and Zuffanti, "General Chemistry," 595 pp., $6. Montag and Filson, "Nursing Arts," 2nd ed., 619 pp., $4.50. Collected Papers of The Mayo Clinic and The Mayo Foundation, Volume XLIV, 786 pp., $12. Routh, "20th Century Chemistry," 564 pp., $5.75. **W. B. Saunders Co., Dept. MH, W. Washington Square, Philadelphia 5, Pa. (Key No. 265)**

Suppliers' News

American Photocopy Equipment Co., manufacturer of copying equipment, announces removal of its offices from **2849 N. Clark St., Chicago 14,** to **1920 Peterson Ave., Chicago 26.**

DePuy Manufacturing Co., Inc., Warsaw, Ind., manufacturer of splints, orthopedic instruments and orthopedic equipment, announces the opening of a West Coast branch office at **718 Mission St., San Francisco, Calif.** The new branch will stock the complete DePuy line, providing fast and efficient service in the Pacific area.

Detroit Steel Products Co., 2250 E. Grand Blvd., Detroit 11, Mich., manufacturer of steel building products, announces the opening of a new plant in **West Elizabeth,** a suburb of Pittsburgh, Pa., for the manufacture of its line of panel shapes for institutional, commercial and light industrial construction.

Charles F. Hubbs Company, 389 Lafayette St., New York 3, announces the establishment of a new **Hospital Supply Department** which will specialize in the development and distribution of paper products for the special use of hospitals and clinics. **Ray J. DiMartino** and **James P. Donohue** have been named co-managers of the new department.

Schenley Laboratories, Inc., 350 Fifth Avenue, New York 1, manufacturer of pharmaceutical products, announces the transfer of the national sales offices from **Lawrenceburg, Ind.** to **New York City.** The move is part of the program to centralize all departmental headquarters in the East.

United States Hoffman Machinery Corporation, 105 Fourth Ave., New York 3, manufacturer of laundry machinery, announces the relocation of its **Central District Office and Warehouse** in **Chicago** in a new building at **3129 W. 47th St.** The sales department, service and parts departments and warehousing are combined at the new location to handle all business for the company in the central area.

Printed in U.S.A.





PREFERRED for COFFEE SERVICE



Hall China has all the qualities essential to good coffee service—a heavy, fireproof body that cannot absorb flavor or aroma; glaze that is pure, leadless and tasteless; thick walls that hold the heat. All Hall coffee pots are made by an exclusive process that inseparably fuses body, glaze, and color. Reasonable first cost and exceptional durability keep replacement at the lowest possible level.

Write on company letterhead for Catalog 53 which lists almost 1,000 different Hall China items and contains a color chart of the 27 beautiful underglaze colors that are available.

THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

Hall Coffee Pots are available in sizes ranging from individual to banquet service.





Hall coffee pots are carefully hand-finished by expert craftsmen.



CONTROLLING "HIDDEN" COSTS

is a *MUST* in Restaurant Operation today

"Insufficient funds" when entertaining the girl friend are embarrassing yet not necessarily fatal. But losses due to excessive "hidden" costs can put a restaurant operation on the rocks.

Controlling needless spoilage, preventing waste, and high preparation costs are major problems in restaurant operation today. Cheapening quality or upping prices is *not* the answer. The sound solution is giving the customer top quality food—*produced with the "hidden" costs under automatic control.* That is what GUMPERT Quality Food Specialties do for thousands of successful restaurants and can do for you.

Ask your GUMPERT Field Man to show you how GUMPERT products and methods can help you plug "hidden" profit-leaks. You'll be glad you did!

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CHOICE OF MORE THAN
40,000 CUSTOMERS

MAKES OVER 300 QUALITY FOOD SPECIALTIES FOR THE RESTAURANT INDUSTRY